320 Peninsula Blvd. Cedarhurst, NY 11516
Phone: (516) 569-2323 Fax: (516) 569-4131

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Patient's Name: _____ Date of Birth: _____

I request and authorize _____ to release healthcare information of the patient(s) named above to:

VIPediatrics, PC
David Rosenberg, MD
320 Peninsula Blvd.
Cedarhurst, NY 11516
Fax: (516)569-4131

This request and authorization applies to:

☐ All healthcare information

☐ Immunization Records

☐ Other: _____

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.