ROSENTHAL & SAMS PEDIATRICS AND ADOLESCENT MEDICINE
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Authorization For Release of Confidential Information

Regarding: _____ _____
Print Patient's Name Date of Birth

I authorize: _____
Name of previous physician holding information

_____
Street Address

_____
City, State Zip

_____ _____
Telephone Fax

☐ to release to Dr. Rosenthal and Dr. Sams **my child's complete medical records**

☐ to release to Dr. Rosenthal and Dr. Sams **my child's Immunizations only**

_____ _____
Signature of Parent or person responsible for child **Date**

This will exempt Dr. Rosenthal and Dr. Sams from any legal liability that may arise as a result of the release/reception of the above-mentioned information. This information is disclosed to you from records whose confidentiality is protected by law. Redisclosure is prohibited without the written permission of the patient or person responsible for patient.