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Authorization to Release Medical Information **from**
Oxford Pediatric Group, PLLC

PATIENT'S NAME ____

PATIENT'S DOB ______________________ PHONE (______)__________________________

I AUTHORIZE INFORMATION TO BE RELEASED TO:

PARENT/PHYSICIAN'S/PRACTICE NAME (PLEASE LIST AS MUCH INFORMATION AS POSSIBLE)

____

ADDRESS ____

CITY______________________________STATE_________ZIP____________

PHONE (______)________________________FAX(_______)______________________________

PURPOSE OF RELEASE

☐ CHANGING PRIMARY CARE PHYSICIAN/CLINIC ☐ INSURANCE/LEGAL ☐SCHOOL SYSTEMS REQUEST

☐ REFERRAL/CONSULTATION ☐ OTHER: ____

☐ PERSONAL - AS A LEGAL GUARDIAN OR PARENT OF THIS PATIENT, I REQUEST TO HAVE MY CHILD'S RECORDS RELEASED FROM OXFORD PEDIATRIC GROUP, PLLC TO MYSELF.

RECORDS TO BE RELEASED

☐ ALL RECORDS ☐ OFFICE NOTES (PLEASE SPECIFY DATES NEEDED) ______________________________

☐ LABWORK ☐ BILLING INFORMATION ☐ PHYSICAL FORM

☐ OTHER: ____

PARENT OR LEGAL GUARDIAN

SIGNATURE______________________________________

PRINTED____

RELATIONSHIP TO PATIENT ___________________________________ DATE _______________________