OXFORD
PEDIATRIC GROUP

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

PATIENT'S NAME _____

PATIENT'S DOB_____PHONE (_____)_____

I AUTHORIZE INFORMATION TO BE RELEASED FROM:

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 □MOVING
□REFERRAL/CONSULTATION □PERSONAL/OTHER □OPG REQUEST

RECORDS TO BE RELEASED

□ ALL RECORDS □ LABWORK □ X-RAY □ HISTORY & PHYSICAL
□ OFFICE NOTES OR TEST RESULTS (PLEASE SPECIFY DATES/TESTS NEEDED) _____
_____

□OTHER_____

PARENT OR LEGAL GUARDIAN

SIGNATURE_____DATE_____

PRINTED_____ DATE_____

RELATIONSHIP TO PATIENT: _____