AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date: __________

Child's Name: ____________________ Date of Birth: ______________
(Please Print)
Child's Name: ____________________ Date of Birth: ______________
(Please Print)
Child's Name: ____________________ Date of Birth: ______________
(Please Print)
Child's Name: ____________________ Date of Birth: ______________
(Please Print)

I hereby authorize and request the complete medical record of the child (ren) listed above be released from:

Downtown Pediatrics
Dr. Vicki Porges
Dr. Anna Zhivotovsky
Lisa Van Brunt, CPNP
36 N. Moore Street
New York, NY 10013
Phone 212-925-3636
Fax 212-925-0633

Please indicate how you would like to receive your records:
□ Records emailed as a PDF to: ________________________ (email address)
□ Records saved to disk to be picked up by: ________________ (authorized person)
□ Records saved to disk to be mailed to: ______________________________
□ Hard Copy to be picked up by (authorized person) or mailed to (mailing address): ______________________________

(In an effort to remain environmentally conscious, we would appreciate you utilizing the paperless options, but understand if you need a hard copy. If the first copy is lost, the second copy will be given electronically only.)
PLEASE CHOOSE ONLY 1 OPTION TO RECEIVE YOUR RECORDS.
PLEASE ALLOW 2-3 BUSINESS DAYS FOR YOUR RECORDS TO BE PREPARED.

______________________________ ______________
Signature of Parent/ Legal Guardian Date