Patient's Name:___________________________________ DOB: ______________

Chart # __________

The undersigned hereby authorizes and requests:

Goodman Pediatrics, LLP
500 Helendale Rd, Suite 200
Rochester, NY 14609
(585)473-7028 phone
(585)473-0051 (fax)

To release information contained in patient's medical records for the purpose of documentation to:

Parent _________________________________

Fax /mail/pick up: ____________________________ Fax number:___________________

School/organization: __________________________ Fax number: __________________

The following documents:

- Immunization records
- Health assessment
- Other ____

The authorization shall expire twelve (12) months from the date signed.

Signature: __________________________ Relationship: _____________ Date: ____________