



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

(please print)

Request Medical Information FROM:

Name of Doctor or /Facility

Address City, State and Zip Code

Phone Number

Fax Number

I hereby authorize the above stated person/facility to release the complete medical record including immunization records to Dr. Iman Bar .

Release records regarding:

Patient Name:

DOB:

Patient Telephone:

Patient Address

Signature of parent / legal guardian

Date