Authorization to Release Healthcare Information

Patients name:_____ **D.O.B.**_____
_____ **D.O.B.**_____
_____ **D.O.B.**_____

I request and Authorize_____ **to release all healthcare information of the above patient/patients named above to:**

CRANFORD PEDIATRICS
Ursula Pogany, M.D.
19 Holly Street,
Cranford,NJ 07016

This Request and Authorization applies to:

- ○ **All Healthcare Information**
- ○ **Immunization Records**

Parent Signature:_____ **Date:**_____

This Authorization expires Ninety Days after its signed