Ejaz Ahmed, M.D., F.A.A.P.
Jill Berry, C.P.N.P.
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670 Rio Lindo Ave Suite 300
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www.chicopediatrics.com
T:(530)343-8522|F:(530)343-3719

AUTHORIZATION FOR RELEASE OF RECORDS

FROM:
Physician: _____

Address: _____

City, State, Zip Code: _____

Phone: ( ) _____-_____ Fax: ( ) _____-_____

I HEREBY AUTHORIZE TO RELEASE A COPY OF MY MEDICAL RECORDS TO:

Chico Pediatrics

Ejaz Ahmed, M.D., F.A.A.P.
Jill Berry, C.P.N.P.
Evbu Ogbeide, M.D.
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Patient Name (Print): _____ DOB: _____

FOR THE FOLLOWING PURPOSE(S):
_____ Continuing Health Care
_____ Other: _____

TYPE OF INFORMATION REQUESTED SHALL INCLUDE THE FOLLOWING:

_____ History & Physical Exam
_____ Surgery Reports
_____ X-Rays
_____ Lab Reports
_____ All Records
_____ Other: _____

Parent Name (Print): _____Date: _____
Parent/Patient Signature: _____
Phone: _____
Address:_____
_____

THIS AUTHORIZATION IS VALID FOR SIX MONTHS FROM DATE OF CONSENT.
I UNDERSTAND I AM ENTITLED TO A COPY OF THIS AUTHORIZATION UPON REQUEST.
I MAY REVOKE MY AUTHORIZATION AT ANY TIME IN WRITING.