Community Pediatrics
1 Billings Road 1st Floor
Quincy, MA 02171

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, the undersigned, _____

authorize Community Pediatrics to release my medical records to the

medical staff at _____,

such information being maintained as confidential.

Signed: _____

Date: _____

Please forward the section of the medical records indicated below to:

Name:

Address:

Phone:

Fax:

Information to be released: _____

Patient's name: _____

Date of Birth: _____