



Yum Pediatrics

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AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTH RECORDS

Patient: _____	DOB: _____
Patient: _____	DOB: _____
Patient: _____	DOB: _____
Patient: _____	DOB: _____
Patient: _____	DOB: _____
Patient: _____	DOB: _____

Address: _____
Phone: _____

I, _____, certify the above request is accurate and hereby authorize the release of these records.

TO:
Name: _____
Address: _____
City, State, Zip : _____
Phone: _____

*** Records requested after November 31st 2023 require a records fee of \$25***

_____ SIGNATURE OF PARENT/GUARDIAN	_____ DATE	_____ PHONE
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Please email this form to office@yumpediatrics.com and go to yumpediatrics.com to pay the records fee.

I hereby authorize, allow, and cause the release of information indicated above. No threat of utter coercive measures have induced me to sign this form, and I do release Yum Pediatrics from, and covenant not to sue Yum Pediatrics for any claim that I have or may have in the future for the release of this information. I understand that I may refuse to sign this form and that refusal to sign will not affect my ability to obtain treatment or payment or eligibility for benefits. I may request to inspect or copy information used/disclosed under this authorization. I understand that I may revoke this consent to release information at anytime, except where actions have already been taken on the basis of this release. If I do not revoke it earlier, this authorization will expire six months after the date specified below, or on the date, event or condition described as: