NAGIREDDI PEDIATRICS,LLC

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please print request in black ink, include either address or fax number.

_____ ____/____/____

Patient Name: Last First MI Date of Birth

Release Information From :

Name: _____
Address: _____
_____
Phone: _____
FAX: _____

Release Information to:
Nagireddi Pediatrics
Phone:636-937-2755
Fax:636-933-2910

***Faxing ispreferred method to receive records**

Reason for Release: _____

Release the following Health Information:

☐ Entire Medical Record ☐ Inclusive Dates Only ___/___/___ through ___/___/___

☐ ☐

_____ _____ _____
Printed Name Date Phone number if questions

_____ _____
Signature Relationship to Patient