



2441 W Horizon Ridge Pkwy

Henderson, NV 89052

Phone: (702)-248-7337 Fax: (702)-478-5465

PLEASE MAIL IF OVER 10 PAGES

Authorization of Medical Records Release

I hereby authorize the use/disclosure of my child's health information as described below; I understand that this authorization is voluntary. I understand that any and all records whether written, oral or in electronic format are confidential and cannot be photocopied or faxed and that this authorization is valid and original.

R

Patient's Name: _____ D.O.B: _____

Records to disclose from:

Physician/ Group: _____

Address: _____

Phone: _____ Fax: _____

Records to be released to: Siena Pediatrics 2441 W Horizon Ridge Pkwy Henderson, NV 89052

Please Check:

[] All medical records including immunizations and growth charts

[] Certain Records: _____

Patient Legal Guardian Signature

Date