Town & Village Pediatrics, L.L.C.

Lisa A. Samuels, M.D.
Erin L. Watson, M.D.
Jennifer L. Trask, M.D.
Amos M. Moberg, M.D.

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT(S) NAME: _____DATE OF BIRTH(S): _____

I HEREBY AUTHORIZE THE PERSON(S) OR HEALTHCARE PROVIDER(S) BELOW:

NAME: _____

ADDRESS: _____

CITY: _____STATE: _____ZIPCODE: _____

TO RELEASE MY PERSONAL HEALTH AND MEDICAL INFORMATION TO THE FOLLWING PERSON(S) OR HEALTH CARE PROVIDER(S):

NAME: _____

ADDRESS: _____

CITY: _____STATE: _____ZIPCODE: _____

PHONE#: _____FAX #: _____

SIGNED: _____ DATE: _____

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