



Medical Home for Children

Authorization for Release of Medical Information

PLEASE FAX THIS 1 PAGE FORM TO 914-594-3693 OR MAIL IT TO THE ADDRESS BELOW

I _____, _____ of the
(Parent / Legal Guardian's Name – Please Print) (Relationship to Patient – Please Print)

minor: _____ D.O.B.: _____
(Patient's Name – Please Print) (Date of Birth of Patient)

hereby give my consent for release of the information contained in his/her medical record
in written or verbal form to nurses and physicians of the Medical Home for Children.

Signature of Parent / Legal Guardian

Date

Medical Home for Children

19 Bradhurst Avenue, Suite 1400 South
Hawthorne, NY 10532

Phone (914) 594-4602 | Fax (914) 594-3693