Records Release Authorization

GATEWAY PEDIATRICS, LTD.
CARE OF INFANTS, CHILDREN & ADOLESCENTS

BRIDGETON: 12255 DePaul Drive, Suite 460, Bridgeton, MO 63044
Tel. (314) 770-2300 • Fax (314) 770-1843

CHESTERFIELD: 224 South Woods Mill Road, Suite 720, Chesterfield, MO 63017
Tel. (314) 434-4010 • Fax (314) 434-1714

I hereby authorize the use of disclosure of my child/children's health information as described below.

Patient's Name:_____ DOB:_____

Patient's Name:_____ DOB:_____

Patient's Name:_____ DOB:_____

Patient's Name:_____ DOB:_____

Please do not send full copies of medical records.

WE ONLY NEED THE FOLLOWING INFORMATION RELEASED.
° Growth Grid, Vaccine Record, Medication Record, Problem List (ONLY)

Gateway Pediatrics, Ltd. is authorized to obtain medical records from the following

_____

Doctor or Medical Center (print)

Address:

_____

_____

Telephone Number: _____ **Fax Number:** _____

This authorization shall be in force and effect for 90 days from date of signed (unless otherwise noted) at which time authorization to use or disclose expires. I understand I have the right to revoke this authorization at any time, in writing, or by mailing notification to this practice.

Parent/Guardian Signature:_____ **Date:** _____

Printed Name:_____ **Telephone Number:**_____

Relationship to Patient:_____