Sierra Pediatrics

AUTHORIZATION FOR THE RECEIPT OF PROTECTED HEALTH INFORMATION

The undersigned authorizes _____ to release protected health
Doctor's Name

information acquired in the course of evaluations and treatments of the following patient(s).

Child's Name	Birthday	Social Security Number

Requested Records:

- ☐ All Records
- ☐ Immunization Records Only
- ☐ _____

Physician:

- ☐ Daniel T. Colombo, M.D., F.A.A.P.
- ☐ Lari L. Frazee, D.O., F.A.A.P.

Please send these medical records to:

Sierra Pediatrics
10581 Double R Blvd.
Reno, NV 89521
Phone (775) 324-0766
Fax (775) 324-0788

In consideration of this consent, I hereby release the above parties from any legal liability for the release of this information.

_____
Date

_____
Signature of Legal Patient Representative