Dr. Oscar F. Sugastti

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patients Name: ___________________________________DOB: _______________

Patients Name: ___________________________________DOB: _______________

Patients Name: ___________________________________DOB: _______________

Patients Name: ___________________________________DOB: _______________

I request and authorize **AAA PEDIATRICS**

2200 Opitz Blvd. Suite 355 Woodbridge VA, 22193
Phone: 703-580-6400
E-fax: 703-580-4550

To release all healthcare information of the patient named above to:

____

(Name of Pediatric office and/or Provider)

Address: ____

Phone: ___________________________

Fax: ___________________________

This request and authorization is valid for 30 days and it applies to:

- All healthcare information relating the following treatments, conditions or dates: ____
- Full medical Record
- Other____

Parent Signature: _________________________________ Date: ______________