Rainbow Pediatrics

Pankaj Sanwal, M.D., F.A.A.P.
Vibha Sanwal, M.D., F.A.A.P.
21141 Sterling Avenue, Suite #1
Georgetown, DE 19947
TEL :(302) 856- 6967
FAX :(302) 855- 0744

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the release of all my health information from

Previous doctor:_____
Pt name;_____DOB_____
Address:_____
Tel # _____
Provider or facility to release information to; RAINBOW PEDIATRICS.

Description of information:

1) Entire medical record

Purpose of release of information:

1) Medical treatment and management
2) Personal use 3) Legal proceeding

This authorization will expire in 1 yr unless otherwise specified

1) I may revoke this authorization any time by notifying Rainbow pediatrics in writing at 1 sterling Ave, suite 1, Georgetown,DE 19947
2) This authorization is voluntary. I understand that my treatment or payment for services will not be affected if I donot sign this authorization
3) I understand that if the organization authorized to receive this information is not a health facility or health plan the information may not be protected by HIPPA

PARENT /LEGAL GUARDIAN_____
DATE_____
NAME & RELATIONSHIP_____