Medical Release Form

Child #1 :

First Name | Last Name | Date of Birth

M M / D D / Y Y

Child #2 :

First Name | Last Name | Date of Birth

M M / D D / Y Y

Child #3 :

First Name | Last Name | Date of Birth

M M / D D / Y Y

Give the complete names & the addresses of the medical facility or organization you are authorizing your Medical records to be released from :

I authorize :

Phone #

Fax

To send to :

Excelcare Alliance, LLC - Pediaplace Pediatrics
ATTN : Medical Records Department

2950 College Drive Unit 2C
Vineland, N.J. 08360

Phone : (856)-692-6000
Fax : (856)-692-0609

Medical Release Form

Copies of the following information :

- [ ] All Medical Records
- [ ] Vaccination Record
- [ ] X-ray reports / Laboratory Tests
- [ ] Other (Please describe) ____________________

Copies of the following information :

- [ ] Continuing Care
- [ ] Personal Copy (Fees May Apply)
- [ ] Insurance Claim
- [ ] Disability Determination
- [ ] Other (Please describe) ____________________

This authorization is in effect : From M M / D D / Y Y
To M M / D D / Y Y
} (Pediod of Time or Event)

Upon the conclusion of that time period or event, this autorization is automatically revoked.

New Patient Registration Form

I further understand that :

- I may refuse to sign this authorization and that my refusal will have no impact on receiving treatment.
- I can inspect or copy any information disclosed under this agreement.
- We continue to offer well child care visits at the office.
- My signing of this document is voluntary.
- I can revoke this autorization at any time and the revocation must be in writing.
- I am entitled to receive a copy of this autorization.

Patient / Legal Guardian Signature

Date