

Siena Pediatrics  
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**Authorization of Medical Records Release**

I hereby authorize the use/disclosure of my child's health information as described below; I understand that this authorization is voluntary. I understand that any and all records, whether written, oral or in electronic format are confidential and cannot be photocopy or fax of this authorization is a valid as the original.

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Patient Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

Records to disclose from:

Physician/Group \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

Records to be released to: Siena Pediatrics  
2847 St. Rose Parkway Ste. 150  
Henderson, NV 89052

Please check:

- All records including Immunization       Certain Records  
Records and Growth Charts

\_\_\_\_\_  
Patient/Legal Guardian Signature      Date: \_\_\_\_\_