



**PALM BEACH PEDIATRIC  
HEMATOLOGY ONCOLOGY**

**12957 Palms West Dr  
Loxahatchee, FL 33470  
561 798-9119**

## **AUTHORIZATION TO RELEASE MEDICAL RECORDS**

Date: \_\_\_\_\_

Physician/Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
(Please Print)

I hereby authorize and request the complete Medical Record of the child listed above to be released to:

**Palm Beach Pediatric Hematology Oncology  
Melissa S. Singer, M.D., P.A.  
12957 Palms West Drive, Suite 103  
Loxahatchee, FL 33470-4989  
(561) 798-9119 (office)  
(561) 798-9193 (fax)**

\*\*This consent for disclosure of medical information will be honored for the request only and will not be transferable for any additional information without the express written consent of the patient. It expires immediately upon completion of this action. I understand I may revoke this consent at any time except to the extent that the action has been taken in reliance on my consent. No other disclosure to other parties by release is permitted without the express written consent of the parent/legal guardian/patient. I have read and fully understand the above information and hereby give my permission\*\*

\_\_\_\_\_  
Signature of Parent / Legal Guardian

\_\_\_\_\_  
Date

PBPHO  
06/25/06