AUTHORIZATION TO FAX

I authorize Delaware Pediatrics to fax the following documents:

NYS Health Appraisal Form ____ Immunization Record ____ Daycare Form ____

Other (Please Specify) _____

Patients Name: _____ D.O.B _____/_____/_____

Organization to Fax Information to: _____

Attention To: _____ Fax Number: _____

Relationship to Patient: _____ Phone Number: _____

Signature: _____ Date: ____/_____/____