Incredible Teddy Foundation
Authorization to Release Medical Information

I authorize the named health care provider to release the information specified to the Incredible Teddy Foundation.

Provider Information

Name: _____
Address: _____
_____
Telephone: _____
Fax: _____
Email: _____

Patient: _____

SS#: _____

DOB: _____

RECORDS AUTHORIZED TO BE RELEASED:

CDH DIAGNOSIS

This information will be used for the purpose of verifying my eligibility for services offered by the Incredible Teddy Foundation.

This authorization will expire one year from the date of the signature below.

_____

Patient Date