7777 Davie Road Extension, suite 100 A Hollywood FL, 33024
Ph: 954-362-9600 Fax: 954-932-3603
peeekaboopediatricare@gmail.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Child's Name: ____ DOB: ________________

To: ____

- You are hereby authorized to release Medical, Social, Academic and Psychological records pertaining to my child to **Peek A Boo Pediatric Care (PPEC)**
- These records are required for the purpose of admission and ongoing skilled care services.

- This information will be utilized in the best interest of my child, and will not released to any other person without written permission from me.

- This authorization will remain in effect from the date of signature and may be canceled by me in written at any time. A photocopy of this will treated in the same manner as the original.

Parent/Legal Guardian's Name: ____ Date: ______________

Parent/Legal Guardian's Signature: ____

Address: ____