MEDICAL RECORDS RELEASE

Please indicate the doctor(s) and their address who treated the patient. _____
_____
_____
_____

Please indicate the name and address of the doctor to whom the records should be sent. _____
_____
_____

Name/Birthdate: child(ren) 1) _____
2) _____
3) _____
4) _____

Address: _____
_____

Phone Number: _____

Please specify treatment dates. _____

Please indicate what information you want released.

_____All information
_____Lab Reports
_____X-ray Reports
_____Mutual Exchange of Information
_____Other:
_____
_____

Patient authorization for release of information

Permission is hereby given to the above named party to release any information indicated above regarding any treatment, diagnosis, and prognosis.

_____ _____

Date Patient or Guardian Signature