
AUTHORIZATION TO RELEASE MEDICAL RECORDS

Child/Patient Name Date of Birth

Child/Patient Name Date of Birth

Child/Patient Name Date of Birth

Child/Patient Name Date of Birth

.....
Growth Chart and
Immunizations Only (no
charge)

Entire Chart
(75 cents per page)

New Physician Name:

Street Address 1

Street Address 2

City

State

Zip Code

Office Phone Number

Fax

Reason for request or
patient departure:

Patient/Legal Guardian
Name:

Patient/Legal Guardian Signature: _____

Date: