Pediatrics

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REQUEST FOR RELEASE OF MEDICAL RECORDS

Patient Information **Please Print!**

Name: _____
Birthdate: _____ SSN#: _____
Current Phone # (in case of questions): _____

Records From:	**Records To:**
_____	_____
MD or Group Name	MD or Group Name
_____	_____
Mailing Address	Mailing Address
_____	_____
City, State & Zip Code	City, State & Zip Code

Information Requested:

_____All Records	_____Other
_____All Dates	_____Specific Dates

I hereby request and authorize the release of requested health care information from the above named party to the corresponding above named party. This authorization will expire one year from the date signed. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the Privacy Officer at Drs. Wilkes and Warner.

_____ _____
Patient or Guardian/Relationship Date

Are you transferring to another practice?_____