



Pediatric Partners

RECORDS RELEASE AUTHORIZATION

TO: Pediatric Partners
_____ (My doctor's name)

I hereby request that you release records to:

Name: _____

Address: _____

Phone # _____ Fax # _____

Records in your possession concerning:

Name of Patient Date of Birth

Address

_____/_____/_____ to ____/____/____ All records
Records from (date) to (date) Immunization Record Only

Signature Relationship to patient