

GLENDALE PEDIATRICS

A PROFESSIONAL CORPORATION
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REQUEST FOR RELEASE OF MEDICAL RECORDS

I hereby authorize and request that **GLENDALE PEDIATRICS** release copies of the medical records

concerning (*patient*) _____, Date of Birth, ____/____/____
dd mm yyyy

for the treatment during the period from: ____/____/____ to: ____/____/____
dd mm yyyy dd mm yyyy

To: _____
Recipient(s) First and Last Name

Address: _____

City: _____ State: _____ ZIP: _____

Reason: App't with Specialist Transferring to New M.D. Other _____

Name: _____ Tel. () _____ ext. _____

Address: _____

City: _____ State: _____ ZIP: _____

Signature: _____ Date: ____/____/____
dd mm yyyy

Relationship to Patient: _____

MAIL COPIES

PICK UP FROM OFFICE