

KID'S DOCS PEDIATRIC ASSOCIATES

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
TO OUR OFFICE

TO: _____

TO WHOM IT MAY CONCERN:

Please release all medical records and information, including labs and x-ray results on the family members listed. Please release this information to the address listed above.

PATIENT NAME: _____

BIRTHDATE: _____

PATIENT NAME: _____

BIRTHDATE: _____

PATIENT NAME: _____

BIRTHDATE: _____

PATIENT NAME: _____

BIRTHDATE: _____

SIGNATURE: _____

Person legally authorized to consent on patient's behalf

DATE: _____