Park Valley Pediatrics, P.L.L.C.

MEDICAL RECORDS REQUEST & RELEASE FORM

Name(s) of patient(s) whose records you are requesting:

1._____ Date of Birth: _____

2._____ Date of Birth: _____

3._____ Date of Birth: _____

4._____ Date of Birth: _____

What kind of records are you requesting? (Please X all that apply)

____ Shot Records ____ Billing/Insurance Info

____ Lab Reports ____ Complete Medical Records*

____ Other (Please describe:) _____

Reason for request:

____ Transfer of Care ____ School/Daycare ____ Legal

____ Other (Please describe:) _____

How do you want to receive this information?

____ Fax # _____ Attn: _____

____ Mail to: _____
Street State Zip

____ In office pick up

Authorized Signature

_____ _____
Name of patient representative Relationship to Patient

_____ _____
Signature Date

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