WALNUT CREEK PEDIATRICS MEDICAL GROUP, INC.

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MEDICAL RECORDS RELEASE FORM

RELEASE FROM:

Name: ______________________
Address: ______________________
City: __________ **State:** ______ **Zip:** ______
Phone: ______________________
Fax: ______________________
Email: ______________________

RELEASE TO:

Name: ______________________
Address: ______________________
City: __________ **State:** ______ **Zip:** ______
Phone: ______________________
Fax: ______________________
Email : ______________________

PLEASE RELEASE RECORDS ON THE FOLLOWING PATIENT(S):

	PATIENT NAME	DATE OF BIRTH	MEDICAL RECORD NUMBER
1.			
2.			
3.			
4.			
5.			

REASON FOR REQUEST:

[ ] Change of Insurance
[ ] Moving
[ ] Other: ______________________

______________________ ______________
Signature of Parent or Legal Guardian   Date

DO NOT SEND FULL RECORDS BY FAX
PLEASE FAX OR EMAIL VACCINE RECORDS ONLY AND MAIL FULL RECORDS
THANK YOU