Northside Pediatrics, PC
Pediatric and Adolescent Medicine

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Medical Records Release Form

I, _____, as parent or legal guardian of _____, do hereby grant

_____

_____

permission for my child's medical & immunization records to be released to the physician indicated below. I understand there may be a charge for copying full medical records.

Please send my child's medical records to:

_____

_____

_____

Patient Name:_____DOB:_____

Parent or Guardian's Name_____

Address: _____

_____

Signature:_____Date:_____