



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: _____

Address: _____

Parent/Guardian Signature: _____

Date: _____