



RELEASE OF MEDICAL RECORDS AUTHORIZATION

**TO: Petite Pediatrics
Charish Barry M.D. F.A.A.P
1525 State Street, Suite 206
Santa Barbara, CA 93101**

I hereby authorize and request you to release to:

Pediatrician: _____
Address: _____
City, State: _____
Fax number: _____

_____ The complete medical records in your possession concerning medical
history and/or treatment during the period from _____ to _____
_____ Only these specific medical records: _____

_____ Include all radiology reports
_____ Include all psychological reports

Patient Name Printed _____
Patient Address _____

Patient Identifiers 1) Date of Birth _____
2) Last 4 digits of SSN # _____

This authorization expires on: _____

Signature of Parent/Legal Guardian or Patient (if <18 years)

Date