



RELEASE OF MEDICAL RECORDS AUTHORIZATION

TO: _____

I hereby authorize and request you to release to:

Petite Pediatrics
1525 State Street, Suite 206
Santa Barbara, CA 93101
(805) 845-1224 (fax)

_____ 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