RELEASE OF MEDICAL RECORDS AUTHORIZATION

TO: **Petite Pediatrics**

Charish Barry M.D. F.A.A.P.

510 W. Pueblo Street

Santa Barbara, CA 93105

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 Date of Birth_____

Authorization Expires on:_____

_____ _____

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