RELEASE OF MEDICAL RECORDS AUTHORIZATION

TO: _____

_____

_____

I hereby authorize and request you to release to:

Petite Pediatrics

510 W. Pueblo Street

Santa Barbara, CA 93105

(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 Date of Birth _____

This authorization expires on: _____

_____ _____

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


Petite Pediatrics