



# Children's Medical Center

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## TO RELEASE ANY PERTINENT RECORDS AND IMMUNIZATIONS

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address \_\_\_\_\_

## RELEASE RECORDS TO: (New Doctor or Parent)

Parent  New Doctor

Pick-up  Mail

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone# \_\_\_\_\_

## REASON FOR RECORDS RELEASE: (Check applicable)

\_\_\_\_\_ Moving

\_\_\_\_\_ Labs/Consults/X-Rays (only)

\_\_\_\_\_ Over age 21

\_\_\_\_\_ Growth Chart (only)

\_\_\_\_\_ For own records

\_\_\_\_\_ For specialist

\_\_\_\_\_ Changing insurance (Name of new insurance: \_\_\_\_\_)

\_\_\_\_\_ Other (please explain)

\_\_\_\_\_ Unhappy with practice (please explain)

Signature \_\_\_\_\_ Date: \_\_\_\_\_

Relationship To Patient: \_\_\_\_\_