Pediatric Medical Records Release Form

Patient Information

Patient Name
Date of Birth
Gender
Address
Phone Number
Parent/Guardian Information
Name
Relationship to Patient
Phone Number
THORE NUMBER
Release Authorization
I hereby authorize the release of medical records FROM:
TO:
Purpose of Release
Information to be Released
Dates of Treatment

her Instructions or Limitations	
nis authorization expires on	
arent/Guardian Signature	
ate	