KidsFirst PEDIATRICS OF STAFFORD

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient_____DOB_____

Address_____

_____

Phone_____

Reason for request_____

If transferring, why?_____

Which parts of the record are needed?_____

I, _____, certify the above request is

Printed name of parent/guardian or patient if 18 yo

accurate and hereby authorize the release of these records.

FROM:_____

_____

TO:_____

_____

_____

Signature of parent/guardian (or patient if 18) Date

Very large charts or repeated requests may incur a charge.

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www.KidsFirstStafford.com