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RECORDS RELEASE AUTHORIZATION

Attn. To: _____
Previous Doctor, Specialist or Hospital

Address: _____

_____

Tel. ( ) - _____ **Fax** ( ) - _____
Phone Number Fax Number

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

Glendale Pediatrics
1500 East Chevy Chase Drive, Suite 250
Glendale, CA 91206-4139

ALL RECORDS IN YOUR POSSESSION CONCERNING _____
Patient Name Date of Birth

_____

TREATMENT DURING THE PERIOD FROM __/__/__ __/__/__
Start Date End Date

Parent Name: _____ **Tel.** ( ) - _____
Phone Number Ext

Address: _____

_____

_____ _____
Signature Date