Medical Record Release

I hereby authorize _____, their agents, officers and employees to provide the following medical records and charts of my child _____ to:

Child's Full Name Date of Birth

To:

Whole Child Pediatrics
20925 Professional Plaza Suite 340
Ashburn VA 20147

Record requested:_____

Reason for request: _____
_____
_____

_____
Signature Date

_____
Printed Name Relationship to Patient

_____
Mailing Address

_____
City, State and Zip

_____
Phone Number

Please:

Mail to address above _____or Mail to Parent's address above_____

I will pick records up_____ Fax to: (_____) _____