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REQUEST FOR RELEASE OF MEDICAL RECORDS

I hereby authorize and request that **GLENDALE PEDIATRICS** release copies of the medical records

concerning (*patient*) _____, Date of Birth, ____/____/____
mm dd yyyy

for the treatment during the period from: ____/____/____to: ____/____/____
mm dd yyyy mm dd yyyy

To: _____
Recipient(s) First and Last Name

Address:_____

City: _____ State: _____ ZIP: _____

Reason: ☐ App't with Specialist ☐ Transferring to New M.D. ☐ Other _____

Name: _____ Tel. ( ) _____ ext._____

Address:_____

City: _____ State: _____ ZIP: _____

Signature:_____ Date: ____/____/____
mm dd yyyy

Relationship to Patient: _____

Information released on this authorization, if disclosed by the recipient, is no longer protected by Glendale Pediatrics

☐ MAIL COPIES ☐ PICK UP FROM OFFICE *

*Copies not paid for or picked up from our office within **60 days** from the date of this request will be destroyed and this authorization shall be rendered invalid.