

Windhaven Pediatrics

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Medical Records Release

To: _____

I, _____, hereby authorize the release of my child(ren)s medical record(s) including: progress notes, growth charts, labs, immunization records, radiologic reports and consultations to Windhaven Pediatrics. Please :

- send the records to the address above.
- fax the records to the number above.
- allow me to pick up my records from your office.

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Signature _____ Date _____
(Legal guardian)

Thank You

www.windhavenpediatrics.com