MYRTLE AVENUE Pediatrics

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I hereby authorize and request Myrtle Avenue Pediatrics Inc to:

☐ send medical records ☐ receive medical records

☐ Office Visit (Dates)	_____	☐ Lab Reports (Date)	_____
☐ Procedure (Date)	_____	☐ X-ray Reports (Date)	_____
☐ Immunization Record	_____	☐ Entire Chart	_____

These records are to be forwarded to/received from:

Address: _____
(Street) (City) (ST) (Zip Code)

Patient Name _____ Date of Birth: _____

Patient Name _____ Date of Birth: _____

Patient Name _____ Date of Birth: _____

Any other information to further identify the patients: _____

Please state reason for requesting medical records: (ex. Changing physicians, moving, insurance)

_____

_____ _____
Signed Relationship to Patient

_____ _____
Printed Name: Date: