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Personal Health Information/Medical Record Release Form

I authorize Daniela Atanassova-Lineva, M.D. Pediatrics, PC to release the following information to:

Patient's Name: _____ **DOB:** _____
Address: _____

Other: _____

Address: _____

Please check the information requested:

- Complete Medical Record
- Immunization Record
- Last Physical Examination
- Specialties Reports
- Other _____

Dr's. Signature _____

I understand and agree that I will be charged at the rate of **\$.50 per page** for copying and any postage and handling to forward these records. Please allow at least 10 business days for processing.

Signature of Parent/Guardian Date of Request

Print Name of Parent/Guardian