

Record Request

Authorization to Release Medical Information To:

Patient (s) Name: _____

Date of Birth: _____

I authorize Delmar Pediatrics to release my medical information to:

Practice

Address

City, State & Zip

Reason for transferring records: _____

I authorize Delmar Pediatrics to obtain my medical information from:

Practice

Address

City, State & Zip

Signature of Patient, Parent, or Guardian