1220 New Scotland Road, Suite 203
Slingerlands, New York 12159
518-439-CARE
fax 518-439-2834

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 Phone Number

______________________________________ ______________________
Address Fax Number

____
City, State & Zip

_______________________________ __________________
Signature of Patient, Parent, or Guardian Date