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Pediatric Partners of Stafford

Authorization to Release Confidential Medical Information

Patient: _____

DOB: _____

Address: _____

Phone: _____

City: _____

State: _____

Zip Code: _____

Information to be Released

_____ Complete Chart

_____ Shot Record

_____ Last Physical

_____ Other (Please Explain)

I, _____, certify the above request is accurate and hereby authorize the release of these records.
(Please Print Parent/ Guardian's Name)

From: _____

To: ***Pediatric Partners of Stafford***

Address: _____

Address: 110 Soaring Eagle Drive
Stafford, VA 22556

Phone: _____

Phone: (540) 720-2126

Fax: _____

Fax: (540) 720-1002

I understand that all sections of this form must be completed before it can be processed.

Parent/ Guardian's Signature: _____

Date: _____