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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) _____

_____, certify the above request is accurate and hereby authorize the
(Please Print Name) release of these records.

From: _____
Address: _____
Phone: _____
Fax: _____

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

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

Parent Signature: _____ Date: _____