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Records Release

I Hereby Authorize You to Release My Child's Records to the Following:
TO: **[All fields required]**
Dr.
_____
_____
(Street Address) (City) (State) (Zip Code)
_____ _____
(Telephone Number) (Fax Number)
FROM: **[All fields required]**
Dr.
_____
_____
(Street Address) (City) (State) (Zip Code)
_____ _____
(Telephone Number) (Fax Number)
Extent of information to be released:
Complete Health Records _____
Office Notes _____ from _____ to _____
Immunizations Only _____
Lab Only _____
X-Ray Only _____
Other _____
Please include any Medical information concerning diagnosis and records of treatment or examination rendered.
Please note there may be a per page charge.
Child's Name: _____ Date of Birth: _____
Child's Name: _____ Date of Birth: _____
Child's Name: _____ Date of Birth: _____
Name of Legal Guardian: _____
_____
(Street Address) (City) (State) (Zip Code)
□ **I would like to pay an additional cost to have my child's medical records mailed certified mail which includes a tracking number. This cost will be determined by the weight of the package being mailed.**
□ **I would not like to pay the additional cost to have my child's medical records mailed certified mail, and I understand**
Caldwell Pediatrics and Wellness Center is not responsible for any medical records that the USPS fails to deliver timely or loses.
Parent's Signature: _____ Date: _____
Telephone Number: _____