Records Release Form

I, _____ do hereby authorize the release of my child/children's medical records from:

_____
Previous Doctor's Name

_____
Previous Doctor's Address

_____
Previous Doctor's Phone Or Fax Numbers

To be released to: **Commonwealth Pediatrics** (Parents, please circle the location most convenient for your family)

Old Jahnke Road Office
7023 Old Jahnke Road
Richmond, Virginia 23225
Ph: 804-320-1353/ Fax: 804-320-6636

Harbour Pointe Office
6510 Harbour View Court, Suite 100
Midlothian, Virginia 23112
Ph: 804-739-8166/ Fax: 804-639-6614

Westchester Commons
15400 WC Commons Way
Midlothian, Virginia 23113
Ph: 804-549-5405/ Fax: 804-379-8162

Child's Name: _____ Birth Date: _____

Child's Name: _____ Birth Date: _____

Child's Name: _____ Birth Date: _____

Child's Name: _____ Birth Date: _____

Child's Name: _____ Birth Date: _____

Mother's Name: _____ Father's Name: _____

Specific Information to be released:

- ❑ All Medical Records (including Immunization Record)
- ❑ Immunization Record Only
- ❑ ADHD/ADD/Behavioral Records
- ❑ Newborn Hospital Records
- ❑ Laboratory Records ALL or Date: _____
- ❑ Radiology Records ALL or Date: _____

Signature: _____ Relationship: _____

Date: _____ Daytime Phone Number: _____

(This release is good for one year after the date that it is signed.)