# THE WORLD OF PEDIATRICS


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Date: _______________

**Description Of Personal Health Information To Be Released:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

For the following patient(s):

1) Patient's Name: ____________________________________
   Patient's DOB: _____________

2) Patient's Name: ____________________________________
   Patient's DOB: _____________

3) Patient's Name: ____________________________________
   Patient's DOB: _____________

4) Patient's Name: ____________________________________
   Patient's DOB: _____________

5) Patient's Name: ____________________________________
   Patient's DOB: _____________

Please, send the records or information to the following fax or address:

Physician/ Practice Name: ______________________________________________
Street Address: _______________________________________________________
City, State, Zip Code: __________________________________________________
Telephone Number: ____________________________________________________
Fax Number: __________________________________________________________

**If you have any questions, please, contact me at __________________________.**

Thank you,

____________________________ ____________________________ ___________
Parent/Guardian printed name Parent/Guardian signature Date