REQUEST FOR RELEASE OF MEDICAL RECORDS

To: Fax # ( ) -

Physician's Name _____ Ph # ( ) -

Address _____

City _____ State _____ Zip _____

I hereby request that my child's (children's) complete medical records (to include, but not limited to, vaccine records, growth charts, clinic notes, all correspondence) be released to the office below for continuity of medical care:

Cevey Pediatrics
414 W. Sunset, Suite 105
San Antonio, TX 78209
Phone (210) 826-0311
Fax (210) 826-0386

I understand that this authorization is valid for 365 days after the date of my signature below, that I may revoke my authorization in writing at any time, and that the disclosed information may be subject to redisclosure by Cevey Pediatrics to other health institutions upon request.

Date _____

Parent's Name _____

Parent's Signature _____

Child's Name Date of Birth

_____

_____

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PLEASE SEND VACCINE RECORDS ASAP

DO NOT FAX RECORDS OVER 15 PAGES PLEASE