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# Pediatric and Genetics, LLC

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## Authorization to Release Medical Records

I hereby request that you transfer medical records including all diagnostic procedures, lab work, immunizations, test results and treatment to Pediatric and Genetics, LLC for the following patients

Patient's legal name \_\_\_\_\_ DoB \_\_\_\_\_

Patient's legal name \_\_\_\_\_ DoB \_\_\_\_\_

Patient's legal name \_\_\_\_\_ DoB \_\_\_\_\_

Patient's legal name \_\_\_\_\_ DoB \_\_\_\_\_

Addressed to Releasing Physician \_\_\_\_\_

Practice \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Authorizing Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Patient (s) (for Pediatrics) \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_