Medical Record Release Authorization Form

I hereby authorize:

Premier Pediatrics
2600 Glasgow Avenue
Suite 213
Newark, DE 19702-4777

To release all medical records of my child/children to:

Office/Doctor/Hospital Name: _____

Address: _____

Fax: _____

Child's Full Name_____

Date of Birth: _____

Child's Address: _____

_____

Daytime Phone: (___) _____

Parent/Guardian Signature: _____

Date: _____