



**REQUEST FOR MEDICAL RECORDS**

Physician's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Address: \_\_\_\_\_  
\_\_\_\_\_

Physician Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Dear Dr. \_\_\_\_\_:

The following individual has requested that the medical records for

\_\_\_\_\_ be released and forwarded to our office:  
Patient Name

Parent/Guardian Name: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

In order for us to fully evaluate this patient's health and make informed decisions, the patient has approved our request of all relevant records in your files. Please include growth charts, immunization records, problem lists, office visit notes, lab results, x-ray reports, and any additional requests listed below:

\_\_\_\_\_  
\_\_\_\_\_

Thank you for expediting this request. Please send the records to our office at the address below:

SEND TO: Northeast Pediatrics  
6540 4<sup>th</sup> St. North, Suite C  
St. Petersburg, FL 33702  
Phone: (727) 526-7337  
Fax: (727) 528-7337

I hereby authorize the release of all necessary medical records to the above facility. I wish for them to be forwarded as soon as possible.

\_\_\_\_\_  
Patient/Parents signature (if minor)

\_\_\_\_\_  
Date

Patients Address: \_\_\_\_\_  
\_\_\_\_\_

Witness Signature: \_\_\_\_\_

