

The Kidz Docs

Pediatric & Adolescent Medicine

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Outside Medical Records Release Form

Please release my child's medical records from the office address listed below and forward them to the Kidz Docs at the address/fax number/email address above:

Patient's Name(s):

1. _____

DOB _____

2. _____

DOB _____

3. _____

DOB _____

4. _____

DOB _____

Signature _____

Date _____

Relationship to Patient _____