SUBURBAN PEDIATRICS

REQUEST FOR MEDICAL RECORDS

TO: ____

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(   ) ______________________________________

PATIENT NAME: ______________________________________

DATE OF BIRTH: ______________________________________

I hereby authorize the release of my medical records as requested below to:

SUBURBAN PEDIATRICS
8643 SHERIDAN DRIVE
WILLIAMSVILLE, NY 14221
(716) 565-9030

SPECIFIC INFORMATION REQUESTED: __________________________

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SIGNED: ______________________________ **DATE:** ____________
(**PARENT/GUARDIAN**)

SIGNED: ______________________________ **DATE:** ____________
(**WITNESS**)