



"Great futures. Small beginnings."

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION (please print):

Child's Name: _____

Date of Birth: _____

Parent/Guardian Phone #: _____

**PLEASE RELEASE ALL MEDICAL RECORDS
FOR TRANSFER OF PATIENT CARE**

FROM:

PHYSICIAN'S NAME _____

NAME OF PRACTICE: _____

PRACTICE PHONE #: _____

PRACTICE FAX #: _____

TO:

PARKSIDE PEDIATRICS, P.A.

Please release a copy of all medical records, including but not limited to: vaccine records, progress notes, operative notes, laboratory / x-ray results, and diagnostic tests.

BY MY SIGNATURE I AUTHORIZE RELEASE OF ALL MEDICAL RECORDS

Parent/Guardian: _____ Date: _____

PARKSIDE PEDIATRICS
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