414 W. Sunset, Suite 105 San Antonio, TX 78209
Ph (210) 826-0311

REQUEST FOR RELEASE OF MEDICAL RECORDS

To: ____Ph:________________________

Physician's name: ____Fax: ______________________

Address: ____

City____State________________Zip______________

I hereby request that my child's (children's) complete medical records (to include, but not limited to, vaccine records, growth charts, clinic notes, all correspondence) be released to the office below for continuity of medical care:

Cevey Pediatrics
414 W. Sunset Rd, Ste 105
San Antonio, Texas 78209
Ph: 210-826-0311 Fax: 1-866-493-1262

I understand that this authorization is valid for 365 days after the date of my signature below, that I may revoke my authorization in writing at any time, and that the disclosed information may be subject to redisclosure by Cevey Pediatrics to other health institutions upon request.

Parent's name:____Date:_________________

Parent's signature: ____

Child's name: ____DOB(s) ________________

Child's name: ____DOB(s) ________________

Child's name: ____DOB(s) ________________

Child's name: ____DOB(s) ________________

Child's name: ____DOB(s) ________________

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PLEASE SEND VACCINE RECORDS ASAP