HIGHLAND PEDIATRICS
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RECORDS RELEASE

To Dr. _____
(Name of physician)

_____
(Address)

_____

I hereby authorize you to release to:

_____
(Name of Dr. to RECEIVE records)

Any information including the diagnosis and records of any treatment or examination rendered to my child/children during the period from _____ to _____.

_____
Patient name date of birth

_____
Patient name date of birth

_____
Patient name date of birth

_____
Patient name date of birth

_____
Patient name date of birth

_____ _____
Parent signature date Witness date