

**LOUDOUN PEDIATRIC ASSOCIATES
19450 DEERFIELD AVE. SUITE 200
LEESBURG, VA 20176
703-723-7337 | 703-723-8278 FAX**

Release of Medical Records

Previous Dr. _____

Address _____

Phone # or Fax # _____

I hereby authorize you to release all medical information, including diagnosis records of treatment of examination and lab and radiology reports.

Send to Dr. _____

19450 Deerfield Ave, Ste 200
Leesburg, VA 20165

For the following patients:

Name _____ DOB _____

Name _____ DOB _____

Name _____ DOB _____

Name _____ DOB _____

Name _____ DOB _____

SIGNATURE (Parent or Guardian) _____ Date _____

Home Address _____

Home Phone _____ Work Phone _____

Signature of Witness _____ Date _____