Release of Medical Records

Doctor/Practice _____

Address _____

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

Send to Dr._____

PLEASE SEND TO CIRCLED ADDRESS BELOW:
(PARENTS: PLEASE CIRCLE THE LOCATION WHERE YOU WANT RECORDS TO BE SENT)
*****PLEASE SEND PAPER RECORDS ONLY*****

Loudoun Pediatric Associates
19500 Sandridge Way Suite 110
Leesburg, VA 20176

Loudoun Pediatric Associates
15 First Street
Berryville, VA 22611

Loudoun Pediatric Associates
205 E. Hirst Rd, Suite 302
Purcellville, VA 20132

Loudoun Pediatric Associates
24430 Stone Springs Blvd, Suite 115
Dulles, VA 20166

For the Following Patients:

Name _____ D.O.B_____

Name _____ D.O.B_____

Name _____ D.O.B_____

Name _____ D.O.B_____

Name _____ D.O.B_____

Name _____ D.O.B_____

SIGNATURE (Parent or Guardian) _____Date_____

Home Address_____

Home Phone _____Work Phone_____

Signature of Witness _____Date_____