Loudoun Pediatric Associates

Release of Medical Records

Doctor/Practice: _____

Address: _____

Phone: _____ Fax: _____

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:

*****PLEASE SEND PAPER RECORDS ONLY*****

Loudoun Pediatric Associates
19500 Sandridge Way Suite 110
Leesburg, VA 20176
Phone (703) 723-7337
Fax (703) 723-8278

Loudoun Pediatric Associates
205 E. Hirst Rd, Suite 302
Purcellville, VA 20132
Phone (540) 338-7065
Fax (540) 338-9482

Loudoun Pediatric Associates
24430 Stone Springs Blvd, Suite 115
Dulles, VA 20166
Phone (703) 957-1247
Fax (703) 665-2376

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_____