WESTCARE PEDIATRICS

RELEASE OF MEDICAL RECORDS & PROTECTED HEALTH INFORMATION

Information regarding patient for whom authorization is made:

Patient Full Name: _____ Date of Birth: _____

Patient Full Name: _____ Date of Birth: _____

Patient Full Name: _____ Date of Birth: _____

Information regarding health care provider or health care entity authorized to disclose this information:

Name: _____

Address: _____City: _____ State: _____ Zip _____

Phone : (_____)_____ Fax: (_____) _____

Please release medical records to:

Westcare Pediatrics
626 Dallas Highway,
Villa Rica, GA 30180
Phone: 770-459-9378
Fax: 770-459-8613
Email: westcarepeds@aol.com

Signatures:

Parent/Legal Representative: _____ Date: _____

Relationship to Patient: _____