Shine Pediatrics and Wellness Center, PA

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Request for release of medical records:

Patient's Name: _____

Date of Birth: _____

Physician's Name: _____

Street Address: _____

City:_____State:_____Zip:_____

Telephone: _____

Fax: _____

This is to authorize your office to release to SHINE PEDIATRICS AND WELLNESS CENTER, PA a copy of the medical records of the above named patient.

Requested By: _____

Patient / Guardian Signature: _____

Date: _____

PRINT, SIGN AND THEN E-MAIL THIS FORM TO shine@shinepediatrics.com OR FAX TO 1-877-878-9118 AND INCLUDE THE WORD 'RECORDS' IN THE SUBJECT LINE.