5303 Plaza Dr
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Hopewell, VA 23860
Office:804-520-0002
Fax: 804-520-2259
admin@caldwellpediatrics.com

Records Release

I Hereby Authorize You to Release My Child's Records to the Following:

TO: **[All fields required]**

Dr.

_____

_____

(Street Address) (City) (State) (Zip Code)

_____ _____

(Telephone Number) (Fax Number)

FROM: **[All fields required]**

Dr.

_____

_____

(Street Address) (City) (State) (Zip Code)

_____ _____

(Telephone Number) (Fax Number)

Extent of information to be released:

Complete Health Records _____

Office Notes_____from_____to_____

Immunizations Only _____

Lab Only _____

X-Ray Only _____

Other _____

Please include any Medical information concerning diagnosis and records of treatment or examination rendered.

Please note there may be a per page charge.

Child's Name:_____Date of Birth: _____

Child's Name:_____Date of Birth: _____

Child's Name:_____Date of Birth: _____

Name of Legal Guardian: _____

_____

(Street Address) (City) (State) (Zip Code)

□ **I would like to pay an additional cost to have my child's medical records mailed certified mail which includes a tracking number. This cost will be determined by the weight of the package being mailed.**

□ **I would not like to pay the additional cost to have my child's medical records mailed certified mail, and I understand**

Caldwell Pediatrics and Wellness Center is not responsible for any medical records that the USPS fails to deliver timely or loses.

Parent's Signature:_____Date:_____

Telephone Number: _____