Pediatric Associates of Plymouth

RECORD RELEASE REQUEST

(INCOMING PATIENT RECORDS)

Please print.

Date: _____

TO: _____

FAX #: _____

I hereby authorize the release of ALL my child's medical records to:

Pediatric Associates of Plymouth

(please choose office)

___3031 Walton Road, Suite C101

Plymouth Meeting, Pa. 19462

610.825.3500

610.825.8502 (FAX)

___50 W. Third Avenue, Suite 400

Collegeville, Pa. 19426

610. 489.2229

610.489.4788 (FAX)

_____ _____

Name of child (PLEASE PRINT) Date of Birth

_____ _____

Name of child (PLEASE PRINT) Date of Birth

_____ _____

Name of child (PLEASE PRINT) Date of Birth

_____

Parent/Guardian's Signature

Forms/Protocols/lgs August 2018