eastbaypediatrics

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Records Request

Please submit this request directly to your previous physician. It is important that we receive medical records before your child's first appointment.

I hereby authorize:

_____
Physician's name

_____
Address

_____
City State Zip Phone#

to release medical records, including immunizations concerning:

Name:_____ DOB:_____

Name:_____ DOB:_____

Name:_____ DOB:_____

_____
Signature of Parent or Guardian Date

This authorization to remain in effect for one year from the date indicated above, or unless revoked in writing by the parent or guardian.