

RECORD RELEASE AUTHORIZATION

I, _____, hereby request and authorize you to release the record(s) of:

Name _____

DOB _____

Name _____

DOB _____

Name _____

DOB _____

Name _____

DOB _____

THE MEDICAL RECORDS WILL BE MAILED TO:

I WILL PICK UP THE MEDICAL RECORDS.

Name _____

Name _____

Address _____

Telephone # _____

I HAVE ENCLOSED THE RECORD RELEASE FEE.
(\$15 for 1 child / \$30 for 2 children / \$40 for 3 or more children)

I WILL PAY UPON PICK-UP.

Check

Check# _____ Amount \$ _____

Credit Card

Amex _____ Visa _____ MC _____ Discover _____

CC# _____ Exp _____ Sec. Code _____

Cash *(Please do not mail cash.)*

REASON(S) FOR REQUEST:

(If moving, please provide new address.)

I understand that records will take at least five (5) days to complete, and will be released upon receipt of payment.

Signature of Responsible Party

Date of Signature

For Internal Purpose Only:

Manager's Initial _____ **Date** _____

Billed Date _____

Mailed Date _____

Staff Initial _____