11601 Robious Road
Midlothian, Virginia 23113
Phone: 804.379.9494
Fax: 804.379.3702

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

TO:
(All fields required)
Dr. _____

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

FROM:
(All fields required)
Dr. _____

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

_____
(Telephone Number) (Fax Number)

Please note there is a charge of $25 associated with obtaining medical records from Capitol Pediatrics.

Reason for Transfer:_____

Child's Name: _____ Date of Birth: _____
Child's Name: _____ Date of Birth: _____
Child's Name: _____ Date of Birth: _____

Parent 1 Name: _____
Parent 2 Name: _____
_____
(Street Address) (City) (State) (Zip Code)

Parent's Signature: _____ Date: _____
Telephone Number : _____