REQUEST FOR RELEASE OF MEDICAL RECORDS FORM

Washington Pediatric Associates, PC
1145 19th Street NW, Ste.708
Washington, DC. 20036
(202)955-5625

Patient Name: _____

Date of Birth: _____

Home Address: _____

_____

_____

Home Phone: ( ) _____ Work Phone: ( ) _____

Please release records to:

_____

_____

_____

_____

Medical Records Requested Form:

Washington Pediatric Associates, PC
1145 19th Street NW, Ste.708
Washington, DC. 20036
(202)955-5625

I hereby authorize the above records to be released from the Washington Pediatric Associates. This request will automatically terminate after 60 days.

Signed: _____ Date: _____

Copying medical records: 76¢ per page plus actual postage and handling.
Please note it will take 30 days to process the request