

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: _____

***\$50.00-Per Child
6-8 Weeks to release***