

REQUEST FOR RELEASE OF MEDICAL RECORDS FROM



Washington Pediatric Associates, PC

Patient Name: _____

Date of Birth: _____ **Soc. Sec. No.** _____

Home Address: _____

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

Please release records to:

Specific records to be sent:

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

SIGNED: _____ **DATE:** _____

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

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Patient Name: _____

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Please release records to:

*Washington Pediatric Associates, PC
1145 19th Street NW, Suite 708
Washington, DC 20036
(202)955-5625
Attention: Dr. Nicole V. Lang MD*

Records requested from:

Specific records to be sent:

All medical records unless otherwise noted

*[I hereby authorize the above records to be released to the Washington Pediatric Associates, PC.
This request will automatically terminate after 60 days.]*

SIGNED: _____ **DATE:** _____