

I hereby authorize:

The Pediatric Group, Inc.
250 N. Robertson Blvd., #404
Beverly Hills, CA 90211
Phone: 310. 273.9533 Fax: 310. 273.8358

To release medical records for the following patients:

Patient Name DOB

Patient Name DOB

Please send medical records to (name of practice):

Type of records requested:

Immunizations Only Complete Medical Records Growth Charts Only

Please indicate specific date range, if applicable: _____

Purpose of Request:

Moving to other practice "Aged Out" Needed for Specialist

Medical records copying fee: \$50 each child for copying complete medical records. Please allow 2 business days for processing.

Signature of parent/guardian

Date

Please return this form: contact@thepediatricgroupbh.com