KidMed

AUTHORIZATION TO RECEIVE MEDICAL RECORDS

The records are coming FROM:

Provider/Facility: _____ Phone: _____

Street Address: _____ City: _____ State: _____

Fax number: _____ Email: _____

I authorize the above practice to release the following medical records for my child:

Child's Name: _____ Phone: _____

Street Address: _____ City: _____ State: _____

DOB: _____ SSN: _____ Medical Record: _____

Treatment Dates: (from) _____ (to) _____

Please transfer all medical records, including immunizations, well-child visits, and sick visits for all dates of service.

The purpose of this request is for continued patient care. Consent expires in 90 days.

Please fax or email this request to:

Fax: 252.606.4325

Email: MLOVELESS@KIDMEDNC.COM

Patient Representative: _____ **Relationship:** _____

Signature: _____ **Date:** _____