Medical Records Release Form

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Records Released From:

Name (i.e. health facility, physican): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Records Released To:

Tosa Pediatrics

8651 W. North Avenue
Wauwatosa, WI 53226
Phone: 414-774-9200
Fax: 414-774-9031

***Please mail records, unless otherwise specified.**

Information to be released:

____ Complete copy of all records ____ Immunization Records ____ Growth Charts

____ Other (specify): _____

I, the guardian/parent/patient authorize the release of all medical records for the above listed patient in accordance with the specification listed above. I understand that I have a right to inspect and receive a copy of the disclosed material. A photocopy of this consent shall be valid as the original.

_____ _____ _____

Signature Relationship Date