Center City Pediatrics

RECORDS RELEASE REQUEST

(PLEASE PRINT)

To: _____

Fax #: _____

Date: _____

I hereby authorize the release of ALL my child's medical records to:

CENTER CITY PEDIATRICS @ BALA CYNWYD

33 ROCK HILL ROAD

SUITE 170

BALA CYNWYD, PA 19004

PHONE: 610-257-9000

MAIL: preferred method to receive records

Name of Child (PLEASE PRINT): _____

Date of Birth: _____

Parent/Guardian's Signature: _____

This record release request is valid for up to 1 year from date faxed

Rev 5.2017