RECORDS RELEASE REQUEST

(PLEASE PRINT)

To: ____

Fax #: ______________________________

Date: _________________

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

CENTER CITY PEDIATRICS

1740 SOUTH STREET

SUITE 200

PHILADELPHIA, PA 19146

PHONE: 215.735.5600

FAX: 215.735.5690

FAX: 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