RECORDS RELEASE REQUEST

To: ____

Fax #: _____________________________ Phone #: _____________________________

Today's Date: __________________

I hereby authorize the release of **ALL** my child's medical records to:
(circle ONE location)

Center City Pediatrics
1740 South St, Suite 200
Phila, PA 19146
Ph: 215-735-5600
Fax: 215-735-5690

Center City Pediatrics Bala Cynwyd
33 Rock Hill Rd, Suite 170
Bala Cynwyd, PA 19004
Ph: 610-257-9000
Fax: 484-270-8133

Center City Pediatrics Fishtown
2365 E York St
Phila, PA 19125
Ph: 215-278-2500
Fax: 215-644-9083

Preferred method to receive records is via FAX since we have Electronic Medical Records

Name of Child (please print): ____

Date of Birth: __________________

Parent/Guardian Signature: ____

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