



AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date: _____

Previous Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Child's Name: _____
(Please Print)

Date of Birth: _____

Child's Name: _____
(Please Print)

Date of Birth: _____

Child's Name: _____
(Please Print)

Date of Birth: _____

Child's Name: _____
(Please Print)

Date of Birth: _____

I hereby authorize and request the complete Medical Record of the child (ren) listed above, be released to:

Place Growing Up Children's Clinic address stamp inside the box.

Signature of Parent / Legal Guardian

Date