

RECORD REQUEST FOR PATIENTS JOINING ORCHARD PEDIATRICS

ORCHARD PEDIATRICS, P.C.
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Please complete the following so that we may obtain your records from your previous physician:

Doctor / Hospital _____

Complete Address _____

I hereby authorize you to release and send copies of:

1. Immunization records only.
2. All records, including HIV testing results, mental health, chemical dependency and any infectious diseases.
3. PKU results

To Orchard Pediatrics for the following children:

_____ DOB _____

_____ DOB _____

_____ DOB _____

Signature of parent or legal guardian:

Witness _____

Date _____