BETHESDA PEDIATRICS

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CONSENT FOR MEDICAL RELEASE TO BETHESDA PEDIATRICS

Upon change of physician we recommend that you fill out the following form to have copies of your child's medical records transferred to BETHESDA PEDIATRICS prior to your 1st visit to our office. Having you complete medical history and pertinent records will be very valuable to the Provider.

CHILD'S FULL NAME: _____ **DATE OF BIRTH**:_____

PARENT/LEGAL GUARDIAN NAME: _____

RELATIONSHIP TO PATIENT:_____

PARENT/LEGAL GUARDIAN PHONE #: _____

PARENT/LEGAL GUARDIAN SIGNATURE: _____

DATE OF REQUEST: _____ **EMAIL ADDRESS**: _____

This is a formal request for the following records:

X **All Available medical records including the following :**
Immunization Records
Height/Weight Scale
Any records pertaining to Chronic Health Conditions/Surgeries etc(including specialist notes, labs, xrays, etc)

FROM: _____ (Previous Pediatrician/Physician)

TO: Bethesda Pediatrics FAX: 480-222-6771 PHONE: 480-222-6770
ADDRESS: 2175 N. Alma School Rd. Ste. C104 Chandler, AZ 85224

Previous Pediatrician/Physician information:

Clinic Name: _____Physician's Name: _____

Address:_____

City, : _____ , State, _____ ,Zip _____

Phone: _____ Fax: _____

Website: _____ General Email Address: _____

Requested on: _____ Completed By: _____