Patience PEDIATRICS

Records Release

I, _____, do hereby authorize the release of my child's/ children's medical records from:

_____

_____

_____

to
Patience Pediatrics
Edward W. Lenard MD
501 Main Street
Monroe, CT 06468
Fax: (203) 452-5561

Child's Name:_____DOB:_____

Child's Name:_____DOB:_____

Child's Name:_____DOB:_____

Child's Name:_____DOB:_____

Mother's Name:_____

Father's Name:_____

Signature:_____ Date:_____