APEX PEDIATRICS
A MEDICAL GROUP

MOHAMMAD KANAKRIYEH, M.D., F.A.C.C., F.A.A.P.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Date: ______________________

I authorize ____
(Name of Provider or Hospital)

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to release all medical records including those that I have listed.

TO: Mohammad Kanakriyeh, M.D.
Apex Pediatrics
399 East Highland Avenue, Suite 329
San Bernardino, CA 20404
(909) 886-1001 – Phone
(909) 886-1107 – Fax

Printed Name: ____

Birth Date: ____

Patient's Signature: ____
(Legal Guardian if under 18 years of age)

Please send all and any medical information as soon as possible, since it is very important in the medical evaluation of my child.

Thank You for your prompt attention to this request.