

Chesterfield Pediatrics, P.C.



5955 Harbour Park Drive
Midlothian, Virginia 23112
Phone: 804.744.4495
Fax: 804.744.0751

I Hereby Authorize You to Release My Child's Records to the Following:

TO:

(All fields required)

Dr. _____

(Street Address) (City) (State) (Zip Code)

FROM:

(All fields required)

Dr. _____

(Street Address) (City) (State) (Zip Code)

(Telephone Number)

(Fax Number)

_____ Please include any information concerning psychiatric problems

_____ Please include any information concerning HIV/STDs

_____ Please include any information concerning abuse

Please include any Medical information concerning diagnosis and records of treatment or examination rendered.

Please note there is a charge of \$0.50 per page for the first 50 pages copied and \$0.25 a page after that.

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____

Father's Name: _____

Mother's Name: _____

(Street Address) (City) (State) (Zip Code)

Parent's Signature: _____ Date: _____

Telephone Number : _____