RAINBOW PEDIATRICS

REQUEST FOR RELEASE OF MEDICAL RECORDS FORM

REQUEST FOR RELEASE OF MEDICAL RECORDS		
Patient's First Name	MI	Last Name
Date of Birth / /	Previous Doctor's Name	
Phone Number ( ) -	Fax Number ( ) -	
Mailing Address 1		
Mailing Address 2		
City	State	ZIP Code

By signing below, I authorize you to release this patient's medical records and immunization history to Rainbow Pediatrics, at the address or fax provided in the above letterhead.

Parent or Legal Guardian's Signature

Date

Panama City, FL Office
2933 Martin Luther King Jr. Blvd.
Panama City, FL 32405
Phone (850) 257-5524
Fax (850) 257-5638

Panama City Beach, FL Office
2933 Martin Luther King Jr. Blvd.
Panama City, FL 32405
Phone (850) 249-3500
Fax (850) 249-3530

THANK YOU FOR CHOOSING RAINBOW PEDIATRICS!