MEDICAL RECORDS RELEASE FORM

Option A: I hereby authorize the release of my child/children's medical records ***FROM***

_____
Name of Doctor or Hospital

_____
Address

_____

_____
Telephone Number and Fax Number

TO

SURF CITY PEDIATRICS
17742 Beach Boulevard, #240
Huntington Beach, CA 92647
(714) 842-0444 Fax (714) 842-8444

Option B: I hereby authorize the release of my child/children's medical records ***FROM***

SURF CITY PEDIATRICS
17742 Beach Boulevard, #240
Huntington Beach, CA 92647
(714) 842--0444 Fax (714) 842-8444

TO

_____
Name of Doctor or Hospital

_____
Address

_____

_____
Telephone Number and Fax Number

Child's Name _____ DOB _____

Child's Name _____ DOB _____

Child's Name _____ DOB _____

SIGNATURE _____ Date _____