REQUEST TO RELEASE MEDICAL RECORDS

Date _____

To: _____

_____

_____

From: _____ **(Parent's Name)**

Re: Medical Records Release

Please release the medical records for _____

Date of birth: ____/____/____

For the following reason(s):

1) _____

2) _____

Please release the records to:

Pedicorp, PC
345 North Main Street, Suite 248
West Hartford, CT 06117

or

Pedicorp, PC
820C Prospect Hill Road
Windsor, CT 06095

Parent's Signature _____ Date _____

Pedicorp, P.C.

345 N. Main Street, Suite 248
West Hartford, CT 06117
Phone (860) 231-8345

820C Prospect Hill Road
Windsor, CT 06095
Phone (860) 285-8251

www.pedicorp.com