

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) _____

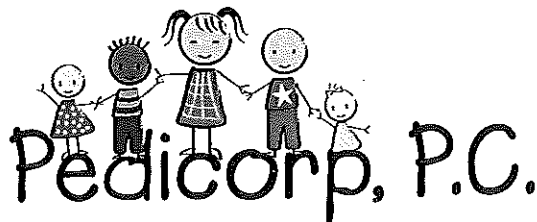
2) _____

Please release the records to:

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

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

Parent's Signature _____ Date _____



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