



FAX

For: Office of Dr.

Fax number:

From (Parent name and phone number):

Today's Date:

Patient(s) name and date of birth:

1.

2.

3.

Comments:

Please release my child's/children's medical records rendered by you or under your supervision. This information will be used to further assist in my child's medical care, and should be released to my child's new pediatric provider:

Performance Pediatrics
23 Aldrin Road
Plymouth, MA 02360
T: 508-747-8277
F: 508-747-1147

Thank you,

(Signature of Parent/Legal Guardian)

DATE