LOUISVILLE PEDIATRIC SPECIALISTS, PSC
6801 DIXIE HWY., STE. 127
LOUISVILLE, KY 40258
PHONE: (502)935-5633 FAX: (502)935-5706

REQUEST FOR MEDICAL RECORDS
(PLEASE PRINT)

To Whom It May Concern:
I, _____, the undersigned and legal guardian of the named individual(s) do authorize and request the release of any and all medical information you may have in your possession.

Please forward this information at your earliest convenience to the office of ***Louisville Pediatric Specialists, P.S.C.*** at the address below.

Records sent from:
Name:_____
Address:_____
Phone Number:_____
Fax Number:_____

Individuals to be covered by this request are:
Child's name (First, MI, Last)

1. _____
2. _____
3. _____
4. _____

Mother's Name:_____
Mother's Address**:**_____
Home Phone**:**_____Work Phone**:**_____
Father's Name:_____
Father's Address:_____
Home Phone:_____Work Phone:_____

Signature:_____Date:_____
Witness:_____Date:_____

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