



Request for Medical Records

To: Name _____
Street _____
City/Zip _____
Fax _____

Re: Patient Name _____
DOB _____

The above patient is under the care of _____ MD in our office.
Please forward the following information as soon as possible:

- Complete medical record
- Summary
- Immunization records
- Lab data (specify: _____)
- Allergy records
- Medical imaging (specify: _____)
- Eye care records
- Other (specify: _____)
- Time period: _____

I hereby authorize _____ to furnish the above requested information contained in my child's medical record to iPediatrics. Our fax # is (973) 810-3233.

(Signature, Parent or Guardian)

(Date)