# Request to Release Medical Records TO:

Fort Payne Pediatrics

Dear Doctor: _____

Address: _____

Phone: _____ Fax: _____

**Please release medical records for:**

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Please mail or fax records to:

ATTN: Medical Records
Fort Payne Pediatrics
1906 Glenn Blvd SW Ste 100-A
Fort Payne, AL 35968-3546
(P) 256.997.5900
(F) 256.997.5995

The signature below serves as authorization to transfer the records.

□ Because the patient is younger than age 18, my signature serves as authorization.

The patient is:
- □ My child
- □ Other dependent

Authorized Signature: _____ Date: _____

□ Because the patient is age 18 or older, the patient's signature must serve as authorization.

Authorized Signature: _____ Date: _____