Westside Pediatrics

Authorization for Release of Health Records

Dear Dr. ____

Address: ____

Phone: ______________________ Fax: ______________________

Please release the complete health records of the following patients:

______________________	DOB: ______________________
______________________	DOB: ______________________
______________________	DOB:______________________
______________________	DOB:______________________

Fax a copy of the patient's health records including vaccinations and growth chart to 310-979-7338
Or mail to: Westside Pediatrics, 12301 Wilshire Blvd., Suite 120, Brentwood, CA 90025

Thank you,

______________________	______________________	______________
Signature	Relationship to Patient	Date

• 12301 Wilshire Blvd., Ste 120 • Brentwood, CA 90025 • 310.979.PEDS (7337) • FAX 310.979.7338 •