Patient Name: ___________________

Date of Birth: ___________________

MEDICAL RECORDS RELEASE

I, ____, authorize the release of my child's medical records from
Name of practice ____________________________________
Address ____
FAX ____
Phone ____

Please send copies of the following medical records: please check all that apply;

Clinic visits ___
Labs ___
X rays. ___
Discharge Summaries ___
Consultations ___

Vital Pediatrics for Complex Kids, LLC

Email: pshearer@vitalpediatrics.com

Thank you

____
(Signature and date)

Patricia Shearer, MD, MS, FAAP
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Phone: 404-986-8756
Fax: 1-833-971-1923
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