

Falmouth Pediatric Associates, LLP

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RECORDS RELEASE / REQUEST

DATE: _____

TO: FALMOUTH PEDIATRIC ASSOCIATES
2 Bramblebush Park
Falmouth, MA 02540
(508) 540-1801

RE: _____
RE: _____
RE: _____
RE: _____

DOB: _____
DOB: _____
DOB: _____
DOB: _____

INFORMATION REQUESTED

_____ Summary of Records

_____ Copy of Records

_____ Immunizations

_____ Growth Chart

_____ Special Testing

I hereby authorize the release of the above information to:

Date Signed: _____
Witness: _____

Signed: _____
Relationship: _____

NOTE: This consent is valid for (1) year unless otherwise revoked. This information is strictly confidential and is only for the person whom it is addressed. No responsibility can be accepted if this information is made available to any other person, including the patient.