



Capitol Pediatrics, P.C.

11601 Robious Road

Midlothian, Virginia 23113

Phone: 804.379.9494

Fax: 804.379.3702

I Hereby Authorize You to Release My Child's Records to the Following:

TO:

(All fields required)

Dr. _____

(Street Address) (City) (State) (Zip
Code)

FROM:

(All fields required)

Dr. _____

(Street Address) (City) (State) (Zip
Code)

(Telephone Number) (Fax Number)

Please note there is a charge of \$25 associated with obtaining medical records from Capitol Pediatrics.

Reason for Transfer: _____

Child's Name: _____ Date of Birth: _____

Child's Name: _____ Date of Birth: _____



Child's Name: _____ Date of Birth: _____

Father's Name: _____

Mother's Name: _____

(Street Address) (City) (State) (Zip Code)

Parent's Signature: _____ Date: _____

Telephone Number : _____