Children's Specialty Group, PLLC

Children's Hospital of the King's Daughters
400 Gresham Drive, Suite 900
Norfolk, VA 23507
Phone: 757-668-7473 Fax: 757-668-7474

Release/Request for Medical Records

Patient Name: Date of Birth: MRN # : Referring Provider:

I, _____, do hereby authorize Developmental Pediatrics to release/receive for review the medical records (including examination, consultation, H&P findings, and radiology/lab results on the above aforementioned patient name).

Medical Records from:
Medical Provider: _____
Address: _____
City: _____
State: _____
Zip code: _____ **Fax:** _____

Release Records to: Name: Developmental Pediatrics
Physical - Address: 400 Gresham Drive; Suite 900
City: Norfolk
State: Virginia
Zip code: 23507

Specify records to be released:

☐Office Notes (Most recent) ☐ Lab Results ☐ MRI/CT/EEG Results

☐Other, specify_____

_____ _____
Signature of Parent/Legal Guardian **Date**

_____
Relationship to the Patient

_____ _____
Witness Name **Date**

This authorization remains valid for a period of 1 year from the date of the signature and may be revoked at any time upon written notification of the patient and/or legal guardian. Further copies of the patient's medical record will entail a fee.

☐Medical Records /School Records Picked up: Date: _____

☐Medical Records/School Records Mailed: Date: _____