LOUISVILLE PEDIATRIC SPECIALISTS, PSC
6801 DIXIE HWY., STE. 127
LOUISVILLE, KY 40258
PHONE: (502)935-5633 FAX: (502)935-5706

REQUEST FOR MEDICAL RECORDS

(PLEASE PRINT)

To Whom It May Concern:
I, ____________________________, the undersigned and legal guardian of the named individual(s) do authorize and request the release of any and all medical information you may have in your possession.

Please forward this information at your earliest convenience to the office of ***Louisville Pediatric Specialists, P.S.C.*** at the address below.

Records sent from:
Name:____
Address:____
Phone Number:____
Fax Number:____

Individuals to be covered by this request are:
Child's name (First, MI, Last)

1. ____
2. ____
3. ____
4. ____

Mother's Name:____
Mother's Address:____
Home Phone:______________________Work Phone:________________
Father's Name:____
Father's Address:____
Home Phone:______________________Work Phone:__________________

Signature:____________________________________Date:_____________
Witness:_____________________________________Date:______________

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