Stonebridge Pediatrics

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RELEASE OF MEDICAL RECORDS

TO: _____
(PHYSICIAN/FACILITY OR PARENT NAME)

_____
ADDRESS CITY ST ZIP

_____
PHONE NUMBER FAX NUMBER

PATIENT'S NAME _____ DOB _____

PATIENT'S NAME _____ DOB _____

PATIENT'S NAME _____ DOB _____

PARENT'S SIGNATURE _____ DATE _____