west center pediatrics P.C.

Release of Information

Patient name: _____

Date of birth: ____ / ____ / _____

Address: _____

City: _____ State: _____ Zip code: _____

I authorize and request medical records be released

From:

West Center Pediatrics
P.O. Box 24368
Omaha, NE 68124

To:

Provider/facility: _____

Address: _____

City: _____ State: _____ Zip code: _____

Dates of information to be disclosed:

Birth to present date (or otherwise specify:_____)

Information to be disclosed:

Entire medical record (or otherwise specify: _____)

_____ _____

Signature (patient, or parent/guardian if patient is a minor) Date

_____

Parent or Guardian Name (Please Print)