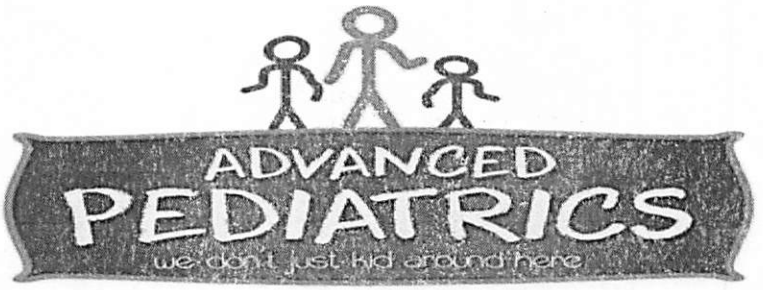

MEDICAL RELEASE

By signing this form, I authorize you to release confidential health information about my child, by releasing a copy of my child's medical records such as; office notes, laboratory results and immunization records to the facility/physician's office listed below.

Medical Records Release from

Facility Name/ Practice Name: _____

Phone: _____ Fax: _____

Please release medical records to:

Advanced Pediatrics
8551 W Lake Mead Blvd #180
Las Vegas NV 89128
P: 702-750-1230 F: 702-750-2388

Type of medical records requested:

- ☐ Unlimited records
- ☐ Limited to the following medical information:

_____

_____

_____

Patients Name: _____ DOB: _____

Parent/Legal Guardian: _____ Date: _____

Signature