Park Cities Pediatrics

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name: _____ Date of Birth: _____

I request and authorize _____
to release medical records of the patient named above to Dr. Matthew L. Simon.

More than 1 patient: _____ D.O.B _____

_____ D.O.B _____

This request and authorization applies to:

☐ All medical records

☐ Other: _____

Parent/Guardian Signature: _____ Date Signed: _____