Consent for Release of Medical Information

I hereby request a copy of my child's medical records from Dayton Pediatrics P.C., 149 Walnut Grove Church Road, Dayton, Tn., 37321, (423)775-5512, be sent to:

Physician's or Practice Name

Address

City, State, Zip Code

Phone:_____Fax Number:_____

Child' Full Name:_______Date of Birth_____

Social Security Number:_____

Parent Signature

Current Address **Phone**

Date of Request sent:_____