Consent for Release of Medical Information

TO: _____

Physician's or Practice Name

_____

Address

_____

City, State, Zip Code

Telephone:_____ **Fax:**_____

I hereby request a copy of my child's medical records be sent to:

Dayton Pediatrics, P.C.
James D. Nelson, M.D., James M. Freuler, P.A.-C. & Elizabeth A. Smith, P.A.
149 Walnut Grove Church Road
Dayton, Tennessee 37321
Phone 423-775-5512 Fax 423-775-0155

Phone:_____**Fax Number:**_____

Child' Full Name:_____**Date of Birth**_____

Social Security Number:_____

_____

Parent Signature

_____

Current Address **Phone**

Date of Request sent:_____