



# PREMIER PEDIATRICS

I, \_\_\_\_\_ hereby authorize the release of my child(s) medical records. Please send the records to the following address:

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I understand that by signing this I am no longer a patient at Premier Pediatrics. \_\_\_\_\_ (initial)

Signature \_\_\_\_\_

Child's Name(s) \_\_\_\_\_

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Date \_\_\_\_\_