JUST KIDS PEDIATRICS
875 AAA Boulevard, Suite C
Newark, Delaware 19713
Phone 302-918-6400

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____

ADDRESS: _____

CITY, STATE, ZIP CODE: _____

FAX #: _____

I request that my child/children's Medical Records :{ immunization records, growth charts, last physical/well child check, last lab, medication history and last sick visit} be released to :

Mail to: **JUST KIDS PEDIATRICS**
875 AAA Boulevard, Suite C
Newark, De 19713

Name of Child/Children:	**Date of Birth:**
_____	_____
_____	_____
_____	_____

I acknowledge that by signing for my child's previous medical records that they may include information relating to AIDS, HIV, Psychiatric Care, behavioral or mental health services, treatment for alcohol and/or drug abuse and Genetic Testing. If you do not wish for this information to be included with your child's previous medical records please initial: _____

_____
PARENT/GUARDIAN SIGNATURE

_____
DATE

Please DO NOT FAX patient prior medical records to our office. We request that they be mailed or given to parent. This signed release is valid for 90 days from date and signature, after 90 days a new request must be completed. Thank you