BURGESS PEDIATRICS

PARTNERS:
James A. Cisco, MD
Sarah G. Cueva, MD
Margaret M. Miller, MD MPH

REQUEST FOR MEDICAL RECORDS

I authorize: _____
(name of doctor or clinic releasing information to Burgess Pediatrics)

To release medical records of: _____
Patient Name Date of Birth

Including:

- ☐ Medical evaluations
- ☐ Vaccination history
- ☐ Growth records
- ☐ Radiology reports
- ☐ Laboratory evaluation

Fax To: 650-321-9556

☐ James Cisco, MD ☐ Sarah Cueva, MD ☐ Margaret Miller, MD

_____

_____

Name of individual requesting records: _____

Relationship to patient: _____

Signature: _____Date: _____