# RECORDS RELEASE

**Date:** _____

**To:** _____

_____

_____

I hereby authorize you to release my child's/children's medical records to Malvika Sharma, MD FAAP. Please send any/all pertinent information including growth charts, immunization and records of any treatment or examination rendered. Please send this information to:

**Malvika Sharma, MD FAAP**
**Pediatric, Adolescents & Young Adults**
9701 B New Church Street
Damascus, MD 20872
Phone: 301-414-0023
Fax: 301-414-0186

**Patient Name(s)** _____

_____

_____

Parent/Guardian Signature: _____