Medical Release Form

I hereby authorize _____ (Previous Office name) _____ (Phone number), _____(Fax Number) their agents, officers and employees to provide the following medical records and charts of my child_____

Child's Full Name Date of Birth

To: **Whole Child Pediatrics**
20925 Professional Plaza Suite 100
Ashburn, VA 20147

Record requested: _____

Reason for request: _____

_____

_____
Signature Date

_____
Printed Name Relationship to Patient

_____
Mailing Address

_____
City, State and Zip

_____
Phone Number

Please: ☐ Fax immunization records to Whole Child Pediatrics at (703)723-8400 and

☐ For non-immunization records, please:

Mail to WCP at address above ☐ or Mail to Parent's address above ☐