# REQUEST FOR RELEASE OF MEDICAL RECORDS

To Dr. ____________________________________________

Address:____________________________________________

City/State/Zip:______________________________________

Phone:_____________________________________________

Fax:_______________________________________________

I hereby request that my records be released to:

Dr.______________________________

**Please mail to: (Preferred)**

**Waukesha Pediatric Associates, LTD.**

**1111 Delafield Street Suite #115**

**Waukesha, WI 53188**

**Phone: (262)542-2536**

**OR**

**FAX (262)542-2791**

(Please fax immunization records or patient records under 15 pages)

Patient Name:______________________________DOB:________________

Parent/Guardian Name:________________________________________

Address:____________________________________________

City/State/Zip:______________________________________

Phone Number:_______________________________________

**SIGNATURE:**_______________________________________