KING GEORGE PEDIATRICS

Ilya Zavelsky, M.D.

Medical Records Release Authorization

TO: _____
(PHYSICIAN'S NAME)

_____
(STREET ADDRESS)

_____
(CITY, STATE, ZIP CODE)

_____
(Office#)

_____
(Fax#)

I hereby request the medical records on

_____ _____
(PATIENT'S NAME) (PATIENT'S DATE OF BIRTH)

To be released to: _____
(PHYSICIAN'S NAME)

King George Pediatrics
11127 Journal Pkwy.
King George, VA 22485
Office # 540-775-6891
Fax # 540-775-6894

_____ _____
(PATIENT'S OR AUTHORIZED SIGNATURE) (DATE)