Sunil Gupta, MD FAAP
www.PediatricsNBC.com

***Request for Information***

## Documents are being requested from:

**Doctor/Office Name**: ______________________________________________

**Address:** ______________________________________________

**Phone Number:** ____________________ **Fax Number:** ____________________

AUTHORIZATION FOR RELEASE OF INFORMATION

**PATIENT NAME:** ______________________________________ **D.O.B.**__________

**PATIENT NAME:** ______________________________________ **D.O.B.**__________

**PATIENT NAME:** ______________________________________ **D.O.B.**__________

**PATIENT NAME:** ______________________________________ **D.O.B.**__________

I declare that I am the parent/legal guardian of the above named patient(s), and hereby request and authorize the above named to release copies of their medical records, including diagnosis, treatments, prognosis, recommendations, and other data to include insurance information to Pediatrics & Newborn Care. Lab, radiology, specialist reports or any other information from other providers regarding the patient and in your possession may be copied and released.

**I am aware that records may contain HIV/AIDS results, sexually transmitted disease, reproductive health, alcohol/drug abuse, child or adult abuse and mental health information and consent to their release. Initial: ____________ Date: __________**

**SELECT FROM THE FOLLOWING**:
1. _______I request **ALL** of the medical records for each patient.
2. _______I request records from the following dates: __________ to ___________.
3. _______Other, please specify: ________________________________.

**PLEASE SEND MY RECORDS TO:**

**Pediatrics & Newborn Care, LLC**
**19415 Deerfield Ave, Suite 303**
**Leesburg, VA 20176**
**(Fax) 703-858-7740**

**Parent/Guardian Name**______________________________________________

**Address**______________________________________________

**Daytime Phone Number**______________________________________________

Your signature authorizes the release of your/your child's medical records.

X

Signature **(required)** Date **(required)**