



AMERICAN KIDS CARE, PC

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REQUEST TO RELEASE MEDICAL INFORMATION

"GO GREEN" Please fax it to our secure encrypted Fax.

Date: _____

From (Previous Provider):

Phone: _____ Fax: _____

RE:

Name of Patient: _____ Date of Birth: _____

Name of Patient: _____ Date of Birth: _____

Name of Patient: _____ Date of Birth: _____

Name of Patient: _____ Date of Birth: _____

Name of Patient: _____ Date of Birth: _____

Please release relevant **Medical Record including Vaccination Record** available for the above named patient(s) and fax to the following provider for the purposes of Continuity of Care.

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For any questions, please contact me at (Phone) _____

Thank you.

Signature of Parent:

Name and Relationship: _____