PEDIATRIC HEALTH CARE
AT NEWTON-WELLESLEY, P.C.

HEALTH CARE FOR THE NEXT GENERATION

Authorization to Release Medical Records

Patient Name: _____

Date of Birth: _____ Telephone # _____

Patient Address: _____

_____

I hereby authorize _____

_____

to release my Medical Records to:

Pediatric Health Care
At Newton-Wellesley, P.C
65 Walnut Street Suite 310
Wellesley Ma, 02481

Signature of Patient (18 years or older) _____ Date: _____

Signature of Legal Representative: _____

Relationship to Patient: _____ Date: _____