# Record Release Request

**Date: _____**

**To: _____**

**_____**

**_____**

**I hereby authorize you to release records to:**

**_____**

**_____**

**_____**

**Any information including the diagnosis and records of any treatment or examination rendered while under your care.**

**Patient's Name: _____**

**_____**
**(Parent Signature)**

**_____**

**_____**

**_____**
**(Address)**

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## Transfer Fee

**Mailed records: $20.00 Per Child _____**
**Pick Up: $15.00 Per Child _____**

**Date: _____ Paid: _____**

**Reason for transfer: _____**

**_____**

**_____**