



Medical Release Form

I hereby authorize _____ (Previous Office name)
_____ (Phone number), _____ (Fax Number)
their agents, officers and employees to provide the following medical records and
charts of my child _____

Child's Full Name

Date of Birth

To: **Whole Child Pediatrics**
20925 Professional Plaza Suite 100
Ashburn, VA 20147

Record requested: _____

Reason for request: _____

Signature

Date

Printed Name

Relationship to Patient

Mailing Address

City, State and Zip

Phone Number

Please: ___ Fax immunization records to Whole Child Pediatrics at (703)723-8400 and

___ For non-immunization records, please:

Mail to WCP at address above _____ or Mail to Parent's address above _____