Pacific Ocean Pediatrics
2216 Santa Monica Blvd., Suite 204
TEL: (310)-264-2100 FAX: (310)-264-2108

AUTHORIZATION of MEDICAL RECORDS

☐ Dear: _____

_____

Please forward my child(ren)'s medical records to

Pacific Ocean Pediatrics
2216 Santa Monica Boulevard, Suite #204
Santa Monica, California 90404
TEL: (310)-264-2100 FAX: (310)-264-2108

OR

☐ Dear: Pacific Ocean Pediatrics

Please release my child(ren)'s medical records to:

Name: _____

Address: _____

Child _____ Date of Birth: _____

Child _____ Date of Birth: _____

Child _____ Date of Birth: _____

Child _____ Date of Birth: _____

Print Name of Parent/Guardian: _____ Date: _____

Signature of Parent/Guardian: _____ Phone: _____

Reason for Request:

___Changed insurance
___Changed doctor
___Moving out of area
___Second opinion
___Legal case
___Personal Use
___Unhappy with care/service
___Other_____