Sunnyhill Pediatric Clinic

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SUNNYHILL PEDIATRIC CLINIC

REQUEST TO SHARE MEDICAL INFORMATION

Request sent to _____

Telephone Number_____ Fax Number _____

Requested by Doctor _____

Patient Name _____

PHN _____ DOB _____

Telephone Number _____

To Whom It May Concern _____, is attending Sunnyhill Pediatric Clinic. The family has provided consent to share/discuss the patients' medical records with

_____

PLEASE DO NOT SEND ORIGINAL RECORDS.

Specific Information Requested

_____

Parents Printed Name _____ Parents Signature _____
Date _____