RAPPAHANNOCK PEDIATRIC ASSOCIATES, P.C .

Authorization to Release Confidential Medical Information

I, _____, request the release of medical
(patient or parent / guardian if child is < 18 years old)

records of:

_____ _____
(Address) Child DOB

_____ _____
(City, State, Zip Code) Child DOB

_____ _____
(Phone number) Child DOB

_____
Child DOB

From:

_____

_____

_____

To:

_____

_____

_____

_____ Date_____
Patient Signature / Parent / Guardian

_____
Relationship

Rappahannock Pediatric Associates, P.C.
2632 Salem Church Rd. Fredericksburg, VA 22407
Dr. Aaronson / Dr. Cochran: **(540) 899-3440**, Dr. Goeden: **(540) 899-3430**