



Medical Records Release

Patient Name: _____

DOB: _____

I hereby authorize the release of all medical records:

To: Skyline Pediatrics P.C.
6340 North Campbell Ave, Suite 256
Tucson, AZ 85718
(520) 577-3333
(520) 577-4685 fax

From: _____
Clinic or Physician's Name

Address

City, State, Zip

_____ / _____

Phone # Fax #

I hereby authorize the release of all medical records from Skyline Pediatrics:

To: _____

Clinic or Physician's Name

Address

City, State, Zip

_____ / _____

Phone # Fax #

Responsible Party Signature: _____

Responsible Part Name (print): _____

Relationship to Patient: _____

Date: _____