Kidstrong Medical Group Inc.
220 Laguna Rd. Suite 5
Fullerton, Ca 92835
Ph: 714-879-2980 Fax: 714-879-5134

Request for Release of Medical Records

Date:_____

To:

_____
(Physician Name)

_____
(Address)

_____
(Phone #) (Fax #)

I request my child's records be released to:

_____
(Physician Name)

_____
(Address)

_____
(Phone #) (Fax #)

Patient Name: _____D.O.B: _____

Patient Name: _____ D.O.B: _____

Parent Name:_____

Parent Signature: _____ Date:_____