# Release of Medical Information

Please release the following medical information:

______ Immunization records & Growth Charts ______ All medical records of the following:

Name/DOB: ________________________________ Name/DOB: ________________________________

Name/DOB: ________________________________ Name/DOB: ________________________________

**From:** Pediatric Care of Chester County, Daniel May, MD, FAAP

638 Wharton Blvd., Exton, PA 19341

Ph (610) 594-6440 Fax (484) 252-2115

**To:**

**Fax Number:**

______ Fax ______ I will pick up at your office

I understand that I have the right to inspect the information to be discussed and I may withdraw this authorization at any time, except to the extent that action has been taken based on this authorization. I understand that this authorization shall expire, without my expressed revocation 90 days the date written below.

________________________________ Signature of consenting party

________________________________ Signature of witness

________________________________ Print Name

________________________________ Print Name

________________________________ Relationship to Patient

________________________________ Relationship to Patient

__________________ Date

__________________ Date