Release of Medical Information

Dear

Please release the following medical information:

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

Name/DOB: _____ Name/DOB: _____

Name/DOB: _____ Name/DOB: _____

To: Pediatric Care of Chester County, Daniel May, MD, FAAP

638 Wharton Blvd., Exton, PA 19341

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

Via: ____ Mail ____ 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 from the date written below.

_____ _____

Signature of consenting party Signature of witness

_____ _____

Print Name Print Name

_____ _____

Relationship to Patient Relationship to Patient

_____ _____

Date Date