MEDICAL RECORDS RELEASE REQUEST

THE PHOENIX CHILDREN'S CENTER, LTD.
1661 EAST CAMELBACK ROAD
SUITE 170
PHOENIX, ARIZONA 85016
(602) 263-9550

Date: _____

I hereby authorize The Phoenix Children's Center, Ltd., to transfer a complete copy of the medical record of my child to:

_____
(DOCTOR/ORGANIZATION)

_____
(ADDRESS)

_____
(CITY, STATE ZIP CODE)

_____ _____
Print name of patient **Patient Date of Birth**

_____ _____
Print name of parent/guardian **Signature of parent/guardian**