



REQUEST FOR PATIENT MEDICAL RECORDS

Date: _____

Patient Name: _____ DOB: _____

Address: _____

Parent/Guardian Name: _____

Previous Doctor/Practice: _____

Phone #: (_____) _____ Fax #: (_____) _____

I hereby give the above mentioned Medical Office / Physician my permission to release any and all medical records pertaining to my child whose name is listed above. Please fax or mail the information to the following address:

Step by Step Pediatrics
21708 Hardy Oak Blvd., Suite 100
San Antonio, Texas 78258
(210) 496-7843 phone
(210) 496-7855 fax

The records sent should include my child's growth chart and Immunization History. If you should have any questions or concerns please contact me at the following number (_____) _____.

Thank you in advance to your assistance.

Sincerely,

Parent/Guardian Signature

Cc: Patient Chart