Van Dorn Pediatrics, P.C.

2500 N Van Dorn Street, Suite 109, Alexandria, VA 22302
Phone: (703) 933-0555 Fax: (703) 933-0999
Web Address: vdpeds.com

REQUEST OF MEDICAL INFORMATION

Name of Facility Providing Records: ______________________________
Phone Number: ____
Fax: ____

I hereby authorize Van Dorn Pediatrics, P.C to receive all medical records for following child/ren:

Child Name: __________________________Date of Birth: __________

Child Name: __________________________ Date of Birth: __________

Child Name: __________________________ Date of Birth: __________

- o Immunization record
- o Medical Record
- o Other: ____

Please FAX records to: 703-933-0999

I, __________________________, hereby authorize your facility to release any information related to my child/ren's healthcare with your practice.
Relationship to patient: _________________________
Parent/Legal guardian signature: ___________________________ Date: ____________