2500 N Van Dorn Street, Suite 102
Alexandria, VA 22302
Phone: (703) 933-0555 Fax: (703) 933-0999
Web Address: www.vdpeds.com

REQUEST OF MEDICAL INFORMATION

Name of Facility Providing Records: _____

Phone Number: _____

Fax Number: _____

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:**
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: _____