The Herbert Kania Pediatrics Group
Affiliated with
Children's & Women's Physicians of Westchester, LLP

MEDICAL RECORDS REQUEST
For The Release of
Medical Information

Patient Name:	Phone Number:
Patient Address: Street, City, State, Zip	
Date of Birth: Mm dd yr	

I hereby request _____
Fill in Name of Physician or Medical Group

_____
Address

to provide my child's medical records to:

Name: The Herbert Kania Pediatric Group
Attention of: Street Address: City, State, Zip Phone:
REASON FOR REQUESTED USE OR DISCLOSURE: [ ] Transfer of health coverage [ ] Personal use [ ] Form completion [ ] Referral [ ] Change in health care provider [ ] Other

_____ _____ _____
Signature of Parent or Guardian: **Relationship to Patient:** **Date:**

_____ _____
Address **Phone**