Record Release Authorization

To: (Dr's name or office) _____

Phone/Fax Number: _____

I hereby authorize and request you to release records to:

PediaCare Of Virginia
Claude F. Karam, M.D.,FAAP
21155 Whitfield Pl Suite102
Sterling VA 20165
Tel: 571.434.7337 Fax: 571.434.7338

The medical records in your possession for my children:

NAME: _____ Date of Birth: _____

NAME: _____ Date of Birth: _____

NAME: _____ Date of Birth: _____

NAME: _____ Date of Birth: _____

NAME: _____ Date of Birth: _____

□ Vaccine Records

□ Last Physical/Well visit

□ Complete Medical Records

X_____ Date: _____

Signature of parent/Guardian