**KENWOOD PEDIATRICS RELEASE OF MEDICAL RECORDS**

DATE:________________________________________

NAME OF PATIENT WHOSE RECORDS ARE BEING REQUESTED OR RELEASED:

______________________________________________ DOB:______________________________

______________ I HEREBY REQUEST MY RECORDS BE SENT TO:

KENWOOD PEDIATRICS
2121 MAIN STREET, SUITE 119
BUFFALO, NY 14214
PHONE: 716-838-6655
FAX: 716-838-6652

RECORDS ARE BEING REQUESTED FROM:

______________________________________________
NAME OF PRACTICE OR PHYSICIAN'S NAME(PRINT)

______________________________________________
STREET ADDRESS

______________________________________________
CITY STATE ZIP

______________________________________________
PHONE

______________ I HEREBY REQUEST MY RECORDS BE RELEASED TO:

______________________________________________________________________
PRACTICE OR PHYSICIAN'S NAME (PRINT)

______________________________________________________________________
STREET ADDRESS

______________________________________________________________________
CITY STATE ZIP

I CONFIRM WITH MY SIGNATURE THAT I AM AUTHORIZED TO REQUEST THE ABOVE RELEASE OF INFORMATION FOR THE NAMED PATIENT.

SIGNATURE: ____________________________________________________________________

RELATIONSHIP TO PATIENT:_______________________________________________________