



PEDIATRICS

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Request To Obtain Medical Records

FROM: _____
Physician/Facility's Name

Address

City/State/Zip

Physician's Phone Number or Fax Number

I, _____, hereby request the following medical records
Parent/Guardian's Name

Immunizations _____ **Problem List** _____ **Growth Chart** _____

For: _____ of _____
Child's Name Date of Birth Current Address

City/State/Zip Current PH # Reason for Release _____ to:

Island Coast Pediatrics
Central Business Office
12550 Professional Park Dr., Suite 11
Fort Myers, FL 33913

Parent/Guardian Signature: _____ Date: _____

Witnessed By: _____ Records Received on: _____

Request sent to CBO for Scanning by: _____

Request Faxed to previous physician by _____