AUTHORIZATION TO RELEASE MEDICAL RECORDS

To: ____

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Telephone :( ) ______________________ Fax :( ) ____________________

I hereby authorize the release of all immunization and/or medical records in your possession are transferred to:

East End Pediatrics, P.C.
Addie J. Briggs, MD
4744 Finlay Street
Richmond, Virginia 23231

Telephone: 804-864-9600 **Fax:** 804-864-9647

Reason: Continuity of care ____

Patient's Name: ________________________ **DOB:** ________________

Patient's Name: ________________________ **DOB:** ________________

Patient's Name: ________________________ **DOB:** ________________

Patient's Name: ________________________ **DOB:** ________________

Signature: ______________________________ **Relationship**: _________

** **Thank you for your timely cooperation****

Date faxed / mailed: _____________ Date received: __________________

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