

**REQUEST FOR RELEASE OF
PATIENT MEDICAL RECORDS**

To: _____
Physician Name
Practice/Hospital Name

Street Address
City, ST Zip Code

Office Number
Fax Number

RE: _____
Patient's Name
_____/_____/_____
Date of Birth

Dear _____:

Please release the medical records for all treatment rendered by you or under your supervision to the above noted patient. This information will be used to further assist in his/her medical care. Please mail or fax these records to:

TLC Pediatrics, P.A.
Daniel M. Moulton MD, FAAP
Jenna O'Brien DO, FAAP
Mystii Nekuza RN, MS, CPNP
Chandra Garvey RN, MS, CPNP
1105 Central Expressway North, Suite 250
Allen, TX 75013
Office: (972) 747-5437 Fax: (972) 747-5497

Your prompt attention to this matter is appreciated. If you have any questions, please feel free to contact us.

Sincerely,

Parent/Guardian Signature

Date