

DATE: _____

DEAR DOCTOR/ CLINIC: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PLEASE RELEASE MEDICAL RECORDS FOR MY CHILD(REN):

FULL NAME

DATE OF BIRTH

1. _____

2. _____

3. _____

4. _____

5. _____

_____ COMPLETE MEDICAL RECORD

_____ LAB REPORTS

_____ X – RAYS

FORWARD THE COPIES TO:

**NORTHEAST PEDIATRIC CLINIC
4520 CENTERVILLE ROAD
VADNAIS HEIGHTS, MN 55127**

PRINT PARENT / GUARDIAN NAME: _____

SIGNATURE: _____