**PURI PEDIATRIC**
**Medical Group, Inc.**

2249 Mowry Avenue, Suite F
Fremont, CA 94598
Phone (510) 797-7766
Fax (510) 797-0595

# *Authorization to Release Medical Information*

Date: _____

Patient's Name: _____
(LAST) (FIRST) (MIDDLE)

Patient's Date of Birth: _____

I hereby authorize **Puri Pediatric Medical Group, Inc.** ☐ **TO SEND** / ☐ **TO RECEIVE** records [CHECK BOX] concerning above named patient.

Name of Doctor/Clinic: _____

Street Address: _____

City/State/Zip: _____

Fax: _____

| | |
|---|---|
| ☐ To send complete medical records | $ 35.00 Fee |
| ☐ Immunization Records & Growth Chart | $ 20.00 Fee |
| ☐ Yellow Immunization Card | $ 20.00 Fee |
| ☐ Chart Storage | $ 50.00 Fee |
| ☐ Immunization Storage | $ 25.00 Fee |

Parent/Guardian of Minor's Signature: _____

PRINT Parent/Guardian Name: _____

Phone/s: _____

*Please allow approximately 7–10 working days to complete your record transfer.*

**Payment is due at the time of request.**