PURI PEDIATRIC
Medical Group, Inc.
Diplomate, American Board of Pediatrics
Veena Puri, MD, FAAP

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Authorization to Release Medical Information

Today's Date: _____

Patient's Name (Last, First, Middle): _____

Patient's Date of Birth: _____

I hereby authorize Puri Pediatric Medical Group, Inc. (check box) ☐ TO SENT / ☐ TO RECEIVE records concerning the above named patient.

Name of Doctor/Clinic: _____

Street Address: _____

City/State/Zip: _____

Fax Number: _____

☐ Send Complete Medical Record $60.00 Fee

☐ Send Immunization Record $30.00 Fee

Parent/Guardian of Minor's Signature: _____

PRINT Parent/Guardian's Name: _____

Phone Number: _____

Please allow approximately 7-10 working days to complete the record transfer.
Payment is due at the time of request.