REQUEST FOR RELEASE AND TRANSFER OF PATIENT'S RECORDS TO WESTSIDE PEDIATRICS

The undersigned _____,
Printed Name of Legal Guardian/Parent

Legal Guardian/Parent of _____,
Printed Name of Patient

DOB: _____, hereby authorizes and requests:
Patient's Date of Birth

_____
Name of Patient's Previous Physician or Group

_____
Address of Previous Physician or Group

_____
Phone Number of Previous Physician or Group

Please fax immunizations and growth chart to (281) 578-8008 and mail all other records to:

WESTSIDE PEDIATRICS
20903 KINGSLAND BLVD.
KATY, TX 77450
Phone: (281) 578-5788

_____ _____
Signature of Parent/Legal Guardian Date