



Request for Medical Records

Please forward complete medical records for my child(ren) to:

Boulevard Pediatrics Medical Group
 16550 Ventura Boulevard, Suite #414
 Encino, California 91436
 Telephone: 818-783-3110 Fax: 818-783-3115

Name	Date of Birth	
1. _____	_____	JJ <input type="checkbox"/> JL <input type="checkbox"/> JS <input type="checkbox"/> JT <input type="checkbox"/>
2. _____	_____	JJ <input type="checkbox"/> JL <input type="checkbox"/> JS <input type="checkbox"/> JT <input type="checkbox"/>
3. _____	_____	JJ <input type="checkbox"/> JL <input type="checkbox"/> JS <input type="checkbox"/> JT <input type="checkbox"/>
4. _____	_____	JJ <input type="checkbox"/> JL <input type="checkbox"/> JS <input type="checkbox"/> JT <input type="checkbox"/>

I give the following physician, medical group, organization and/or its representatives, permission to copy and forward my child(ren)'s medical records to Boulevard Pediatrics.

Physician's office or Medical Group: _____
 Phone Number: _____
 Fax Number: _____

 Parent/Guardian's Signature

 Date

 Print Parent/Guardian's Name

 Parent/Guardian's Phone #