



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

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 #