



## 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 #