



# 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"/>	KL <input type="checkbox"/>
2. _____	_____	JJ <input type="checkbox"/>	JL <input type="checkbox"/>	JS <input type="checkbox"/>	KL <input type="checkbox"/>
3. _____	_____	JJ <input type="checkbox"/>	JL <input type="checkbox"/>	JS <input type="checkbox"/>	KL <input type="checkbox"/>
4. _____	_____	JJ <input type="checkbox"/>	JL <input type="checkbox"/>	JS <input type="checkbox"/>	KL <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 #