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.	_____	_____	JL ☐	JS ☐	KL ☐	KB ☐
2.	_____	_____	JL ☐	JS ☐	KL ☐	KB ☐
3.	_____	_____	JL ☐	JS ☐	KL ☐	KB ☐
4.	_____	_____	JL ☐	JS ☐	KL ☐	KB ☐

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 Medical Group, Inc.

Physicia**n's office or Medical Group:** _____
Phone Number: _____
Fax Number: _____

_____ _____
Parent/Guardian's Signature Date

_____ _____
Print Parent/Guardian's Name Parent/Guardian's Phone #