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16650 Ventura Blvd #414
Encino, CA 91436
818 783-3110

RECORD REQUEST

Physician's Name: _____

Physician's Address: _____

Physician's Phone: _____ Fax Number: _____

I authorize the release of my Medical Records to Dr. _____.
Please transfer the **Immunization record, growth chart, and last Physical**, of my children listed below and Mail them to Boulevard Pediatrics, 16550 Ventura Blvd #414, Encino, Ca. 91436 or **Fax to (818) 783-3115**.

Patient Name _____ DOB _____

Patient Name _____ DOB _____

Patient Name _____ DOB: _____

Patient Name _____ DOB: _____

Parent/Guardian: _____

Signature: _____

Date: _____

