

Authorization for Disclosure of Health Records and Information

Patient Name: _____ Birth Date: _____

Records requested from: _____

Releasing records to: Swift Creek Pediatrics
13700 St. Francis Boulevard, Suite 501
Midlothian, Virginia 23114
Phone: (804) 378-4420
Fax: (804) 378-4440

Patient/Legal Guardian gives Swift Creek Pediatrics authorization to obtain all x-ray reports, lab reports and medical records.

Signature: _____

Printed Name: _____

Relationship to Pt: _____

Date: _____

Witness: _____