VALLEY MEDICAL CLINIC
PEDIATRICS
1436 GUNTER AVENUE
GUNTERSVILLE, AL 35976
(256) 202-1111 (256) 202-1112 FAX

DR. FRINE T. ROCA, MD AMBER LEWIS, PEDIATRIC CRNP

TO: _____

PHONE: _____ FAX: _____

PATIENT NAME: _____ DOB: _____

I HEREBY REQUEST THAT YOU RELEASE THE FOLLOWING INFORMATION FROM MY MEDICAL RECORD FOR THE PURPOSE OF ONE OF THE FOLLOWING:

____ TREATMENT ____ PAYMENT ____ OTHER

INFORMATION REQUESTED:

_____ ALL RECORDS
____ DEMOGRAPHICS
____ ECHO/GXT REPORT
____ EKG/EEG REPORT
____ PATH/LABS
____ PROGRESS/OFFICE NOTES
____ RADIOLOGY REPORTS
____ VACCINE RECORD
____ OTHER: _____

_____ _____
PATIENT/PARENT SIGNATURE **DATE**

_____ _____
WITNESS **DATE**