

Chippenham

C h i p p e n h a m P e d i a t r i c a n d A d o l e s c e n t M e d i c i n e

Pediatrics

Records Release Form

I, _____ do hereby authorize the release of my child's/children's
medical records from:

to the Chippenham Pediatric and Adolescent Medicine location circled below:
(Parents, please circle the location most convenient for your family.)

Harbour Pointe Office
6510 Harbour View Court, Suite 100
Midlothian, VA 23112

Old Jahnke Road Office
7023 Old Jahnke Road
Richmond, VA 23225

Child's Name: _____ Birth Date: _____

Other Children:

Name: _____ Birth Date: _____

Name: _____ Birth Date: _____

Name: _____ Birth Date: _____

Name: _____ Birth Date: _____

Mother's Name: _____ Father's Name: _____

Signature: _____