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PERMISSION TO RELEASE MEDICAL NOTES

The completion of this form authorizes the providers at Pediatrics at Newton Wellesley to communicate with and request medical information from the professionals below regarding the following patient:

Patient's Name: _____ DOB: _____

Facility/Name of Provider: _____

Date of Service/Visit: _____

Check One:

- Please fax notes/test results to Pediatrics at Newton Wellesley (fax #: 617-928-0178)
- Please mail hard copy of notes/test results to Pediatrics at Newton Wellesley

Signature of Parent/Guardian or Patient (If > 18 years old)

Date

Printed name of Parent/Guardian or Patient (if > 18 years old)