RECORD RELEASE REQUEST

PEDS WORLD ASSOCIATES
3449 WILKENS AVE SUITE 308
BALTIMORE, MD, 21229
PHONE- (410)-646-1200
FAX- (410)-646-1211

Date:_____

Attention: NR _____

Phone # :_____ Fax # :_____

SEND TO DR. DORA RIOJA-MAZZA

I hereby authorize you to release to dr. Rioja-Mazza any information including the diagnoses and records of any treatment or examination rendered to me during the period of care.

Immunization Records **Recent Notes** **Labs** **All Records**

Patient Name:_____

Date Of Birth:_____

Parent/Guardian Name Print:_____

Signature:_____

Address:_____

_____

Phone #:_____