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# BLUESTONE PEDIATRICS PLC

## MEDICAL RECORDS RELEASE FORM

**RELEASE FROM:**

_____
Physician/Clinic's Name

_____
Address

_____
City State Zip

**RELEASE TO:**

**BLUESTONE PEDIATRICS**
4059 Quarles Court
Harrisonburg, VA 22801
Phone (540) 437-4800
Fax (540) 437-9012

Please release medical records on the following patient(s):

1. _____ Date of Birth: _____
2. _____ Date of Birth: _____
3. _____ Date of Birth: _____
4. _____ Date of Birth: _____

Parent's Name: _____

Parent's Address_____
Street City State Zip

Reason for
Transfer:_____

_____

_____ _____
Signature Date

**Please do not fax over 10 pages**