495 East 4500 South, Suite 200
Salt Lake City, Utah 84107
Phone: (801) 595-8844 Fax: (801) 506-0188

RELEASE OF MEDICAL INFORMATION

Please mark one of the following:

☐ I am requesting records to be released from a prior physician to Comfort Care Pediatrics

☐ I am requesting records to be released from Comfort Care Pediatrics to a medical office/person

Please provide the information of whom we are requesting from or releasing to:

Name (Physician, Clinic, Hospital or parent): _____

Address: _____

Phone: _____Fax: _____

I hereby authorize the release of the following records:

□ Problem List
□ Immunization Record
□ Growth Chart
□ Medication List
□ Other: _____

□ Reviewed by MD
□ Scanned/Logged

Patient(s) Name: Date of Birth

1)_____ _____
2)_____ _____
3 _____ _____
4) _____ _____

I hereby authorize the release of the above-mentioned medical records and will not hold the releasing party responsible for any legal liability that may arise as a result of the release of this information.

Signature of parent/legal guardian Please Print Name Date:
X_____ _____ _____

Witness Please Print Name Date
X_____ _____ _____