REQUEST FOR RELEASE OF MEDICAL RECORDS

To: ______________________________ M.D.
Address: ______________________________
City: ______________ State: _____ Zip: _____
Phone: ______________ Fax: ______________

I hereby request that my child's medical records be released to

Sherry Nussbaum, M.D.
1008 N. Bowen Rd
Arlington, TX 76012

Phone: 817-861-2288 Fax: 817-460-1595

Child's Name: ______________________________
Date of Birth: _____/_____/_____
Home Phone: ______________ Alt #: ______________

Parent/Guardian Name: ______________________________

Parent/Guardian Signature: ______________________________

Date: ____/____/____