



COMPLETE CHILDREN'S HEALTH, P.C.

REQUEST FOR RECORDS BY COMPLETE CHILDREN'S HEALTH FOR TREATMENT OF PATIENT

Patient Name: Last First MI

____/____/____
Date of Birth

The undersigned hereby authorizes:

(Name, address, phone, and fax of
Releasing Facility)

To Release Information to:

**COMPLETE Children's Health
Medical Records**

Fax: 402-327-6092

***Faxing is the preferred method to
receive records***

Please fax entire medical record including immunization history.

Printed Name

Date

Phone number if questions

Signature

Relationship to Patient