Request for Release of Medical Records to
One Pediatrics at Simpsonville

Practice _____

Address _____

_____

Phone _____

I authorize you to furnish a copy of the medical records

Of: _____

Birthdate: _____

To: One Pediatrics at Simpsonville
133 Buck Creek Rd
Simpsonville, KY 40067
Phone 502-405-2020
Fax 502-405-2079

Parent's Signature Date Requested

_____

Parent's Contact Number