MEDICAL RECORDS RELEASE FORM

Preeti Bimbrahw MD

To Whom It May Concern:

By this letter, I authorize release of my medical records to:

VIERA PEDIATRICS – 8095 Spyglass Hill Road, Suite 104, Melbourne FL 32940 phone: 321.241.6400 Fax: 321.428.3945

From:

Name of Physician/Hospital/ Facility

_____

Fax/phone number:

_____

I would like:

_____Complete Medical Records

Name of child_____

Childs date of birth_____

Thank you,

_____

(Patient or Parent/Guardian Signature)