

Children's Specialty Group, PLLC

Children's Hospital of the King's Daughters

400 Gresham Drive, Suite 900

Norfolk, VA 23507

Phone: 757-668-7473 Fax: 757-668-7474

Release/Request for School Records

Patient Name:
Date of Birth:
MRN # :
Referring Provider:

I, _____, do hereby authorize Developmental Pediatrics to release/receive for review the school records on the above aforementioned patient name.

School Records from:

School: _____

Address: _____

City: _____

State: _____

Zip code: _____ **Fax:** _____

Release Records to: Name: Developmental Pediatrics

Physical - Address: 400 Gresham Drive; Suite 900

City: Norfolk

State: Virginia

Zip code: 23507

Specify records to be released:

Psychological and/or Educational testing results (current) IEP/IFSP/504 plan

Other, specify _____

Signature of Parent/Legal Guardian

Date

Relationship to the Patient

Witness Name

Date

This authorization remains valid for a period of 1 year from the date of the signature and may be revoked at any time upon written notification of the patient and/or legal guardian. Further copies of the patient's medical record will entail a fee.

Medical Records /School Records Picked up: Date: _____

Medical Records/School Records Mailed: Date: _____