Kelly Parker-Mello, MD
Sherry Pleau, PNP

REQUEST FOR RELEASE OF MEDICAL RECORDS

REGARDING PATIENT(S):

Name & DOB: ____

Name & DOB: ____

Name & DOB: ____

Name & DOB: ____

To whom it may concern:

I hereby request that a copy of my child's medical records be released and faxed to **866-625-5194**, or mailed to:

Tailored Pediatric Medicine
500 Market Street, Unit 2B
Portsmouth, NH 03801-3434

Please include a copy of all pertinent laboratory and xray findings.

Thank you for your assistance in this matter.

Parent/Legal Guardian Name: ____

Parent/Legal Guardian Signature: ____

Date: ______________________