Anrae G. Applewhite, MD and **Alexi M. Snodgrass, PA-C**

106 C. Fairview Dr. Franklin, VA 23851 Ph: 757-569-9397 Fx: 757-569-0353 Email : rootsandwings.pediatrics@gmail.com

Record Release

I hereby authorize : **Office / Dr. Name: _____**

Address: _____

Phone / Fax # : _____

to RELEASE copies of ALL MEDICAL RECORDS compiled during office visits and / or hospital admission for :

Patient Name : _____

Date of Birth : _____ Phone Number : _____

Address : _____

_____

From (date) : _____ To (date) : _____

Release Medical Records To :

Roots & Wings Pediatrics
106-C Fairview Dr.
Franklin, VA 23851

- OR -

_____

_____

_____

I place no limitations on history of illness or diagnostic and therapeutic information including any treatment for aides, drug abuse, psychiatric disorders, or HIV infections.

This authorization can be revoked, but not retroactive to the release of information made in good faith.

Parent / Guardian Name (Print) : _____

Signature : _____ Date : _____
(Patient, Parent or Legal Guardian, Legal Representative)