



**REQUEST FOR MEDICAL RECORDS**

Please release medical records from:

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**Transfer Records to: ALL Pediatrics of**

**Alexandria**

1500 N Beaugard, Suite 200  
Alexandria, VA 22311  
(703) 436-1215

**Lorton**

9010 Lorton Station Blvd., Suite 100  
Lorton, VA 22079  
(703) 436-1200

**Lakeridge**

1990 Old Bridge Road, Suite 101  
Woodbridge, Virginia 22191  
(703) 491-4131

**FAX (703) 499-9670**

Records can be mailed or faxed to our office.

**Names of All Children**

**DOB:**

1 \_\_\_\_\_  
2 \_\_\_\_\_  
3 \_\_\_\_\_  
4 \_\_\_\_\_  
5 \_\_\_\_\_

**Reason for transfer of records:**

- Change in insurance       Relocation       Other

**New Address and Telephone Number of Family:**

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I, \_\_\_\_\_, hereby authorize your facility to release any information, including the diagnosis, prognosis, treatment, and any pertinent information related to my child's healthcare for the dates of service with your practice.

**Signature**

**DATE** \_\_\_\_\_

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**BUSINESS USE ONLY**

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