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## Medical Records Request

<b>Child's name and date of birth:</b>
<b>Name and address of parent:</b>

**Retrieve records from another doctor or provider:**

<b>Send my child's records to <u>Night and Day Pediatrics:</u></b>	Check one: <input type="checkbox"/> All Records <input type="checkbox"/> Last year <input type="checkbox"/> Immunizations only	Doctor or Name of practice:	Phone:  Fax:	Address:
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**Send records to another doctor or provider:**

<b>I give Night and Day Pediatrics permission to send my child's records to:</b>	Check one: <input type="checkbox"/> All Records <input type="checkbox"/> Last year <input type="checkbox"/> Immunizations only	Doctor or Name of practice:	Phone:  Fax:	Address:
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**Signature:** \_\_\_\_\_

Confidentiality Notice: The information contained in this facsimile message is privileged and confidential information intended for the use of the individual or entity named above. Health care information is personal and sensitive and should only be read by authorized individuals. Failure to maintain confidentiality is subject to penalties under state and federal law.