GLENDALE PEDIATRICS
A PROFESSIONAL CORPORATION
1500 E. CHEVY CHASE DR. SUITE 250 GLENDALE, CALIFORNIA 91206
TEL (818) 246-7260 FAX (818) 502-9247
www.glendalepeds.com

RICHARD H. FEUILLE, M.D.
JENNIFER A. HARTSTEIN, M.D.
JAMES C. HENRY, M.D.
BRADLEY M. BURSCH, M.D.
NICOLE A. FABRIS-CARRAL, M.D.
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RECORDS RELEASE AUTHORIZATION

To: _____
Doctor or Hospital

Address: _____

_____

Tel. ( ) - _____ **Fax** ( ) - _____
Phone Number Fax Number

I HEREBY AUTHORIZE AND REQUEST YOU TO RELEASE TO:

Glendale Pediatrics
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Glendale, CA 91206-4139

ALL RECORDS IN YOUR POSSESSION CONCERNING _____
Patient Name Date of Birth

_____

TREATMENT DURING THE PERIOD FROM __/__/__ __/__/__
Start Date End Date

Name: _____ **Tel.** ( ) - _____
Phone Number Ext

Address: _____

_____

_____
Signature

_____
Date

_____
Witness

_____
Date