Children's Brain Academy
1010 E Mcdowell Rd #301
Phoenix, Az 85006

PH:602-222-2234 Ext 125

MEDICAL RECORDS RELEASE FORM

CHILD'S NAME _____ ***Date ofBirth:*** _____

I _____ , authorize _____

to release my son's/ Daughter's Medical records to Children's Brain Academy.

Date: _____

_____
Parent / Guardian

Previous Pediatrician's Information

_____

_____

_____

Ph: _____ Fax: _____