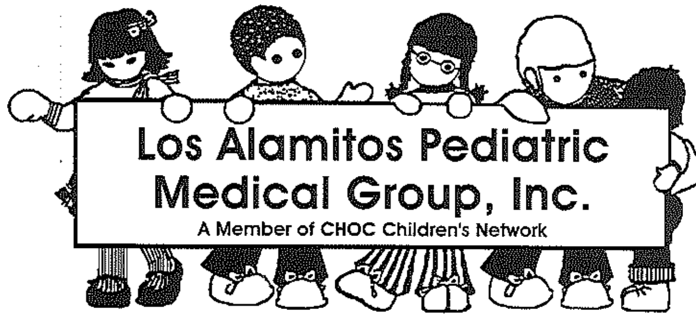

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My signature authorizes Los Alamitos Pediatric Medical Group, Inc, A Member of CHOC Children's Network, to release the medical records as indicated.

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Release the following records:

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Medical Records from dates: ______________ to ______________

Patient Name: ____________________ Date of Birth: ______________

Signature of parent or legal guardian:

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Parent / Guardian Signature	Please print legibly	Date

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