



Adventure Pediatrics  
5960 Getwell Road Suite 102  
Southaven , MS 38672-7318  
Fax: (662) 214-6249  
Phone: (662) 443-4408

REQUEST FOR RELEASE OF MEDICAL RECORDS

REGARDING PATIENT: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

To whom it may concern: I hereby request that a copy of my child's medical records be released and forwarded to:

Adventure Pediatrics  
5960 Getwell Road  
Suite 102  
Southaven , MS  
38672

Please include a copy of all pertinent laboratory and xray findings.

Thank you for your assistance in this matter.

Parent's Signature: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_