William T. Lin, MD, PA
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Medical Records Release

I, _____, HEREBY AUTHORIZE

_____
Name of Physician

_____
Address

_____
City, State and Zip

_____
Phone # Fax#

To release my child(ren)'s medical records including progress notes, growth charts, X-ray, lab and immunization records to Dr. William T. Lin, M.D., P.A.

_____ _____
Patient's Full Name Date of Birth

_____ _____
Patient's Full Name Date of Birth

_____ _____
Patient's Full Name Date of Birth

- ❑ Please mail records to the above address (preferred).
- ❑ Please fax immunization records now and mail records to the above address.
- ❑ Please fax records to the above fax number.
- ❑ Please allow me to pick up my records from your office.

_____ _____
Signature of Parent or Guardian Date