Boulevard Pediatrics Medical Group

Comprehensive, Personalized Care
of Infants, Children and Adolescents

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RECORD REQUEST

Physician's Name:_____

Physician's Address:_____

Physician's Phone:_____Fax Number:_____

I authorize the release of my Medical Records to Dr._____.
Please transfer the **Immunization record, growth chart, and last Physical** of my children listed below and mail them to Boulevard Pediatrics, 16550 Ventura Blvd #414, Encino, Ca. 91436 or **Fax to (818) 783-3115.**

Patient Name_____DOB_____

Patient Name_____DOB_____

Patient Name_____DOB:_____

Patient Name_____DOB:_____

Parent/Guardian:_____

Signature:_____

Date:_____