Release of Records to
Pediatric Associates of Avon

I, _____ the parent/guardian of the child/children listed below request all of the medical records for the child/children be forwarded to Pediatric Associates of Avon.

To: Pediatric Associates of Avon
1115 Ronald Reagan Parkway
Suite 136
Avon, In. 46123
Phone 317-217-2900
Fax 317-217-2909

From: _____
Address: _____
_____
_____
Phone: _____
Fax: _____

Child's Name	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Parent/Guardian: _____

Date of Request: _____

Select the accepting pediatrician:

Dr. Jason Cosgrove _____

Dr. Eve Gill _____

Dr. Jessica Lopez _____

Dr. James Shmalo _____