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**Request for Release of Medical Records**

**I hereby request release of all office/progress notes, growth charts, immunization records, laboratory test results or summary of the above information and any other pertinent medical information pertaining to my child/children listed below.**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

**Please release information to:**

**Anchor Pediatrics  
8360 Sierra Meadows Blvd.  
Naples, FL. 34113**

**Ph: 239-403-6300**

**Fax: 239-430-7810**

**Reason records are being released:** \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/ Guardian

\_\_\_\_\_  
Date

**Records being released from:** \_\_\_\_\_

**Ph:** \_\_\_\_\_

**Fax:** \_\_\_\_\_

