BLUE RIDGE PEDIATRIC ASSOCIATES, LTD.
337 WESTSIDE STATION DRIVE
WINCHESTER, VIRGINIA 22601
Phone: (540) 667-5400
Dr. Daniel C. Schiavone
Dr. Gita Haddadi

RECORDS RELEASE REQUEST

TO: _____ (Practice/Physician)

_____ (Address)

_____ (City) _____ (State) _____ (Zip)

I hereby request that medical records be released to:

Blue Ridge Pediatric Associates, Ltd.
Daniel C. Schiavone MD
Gita Haddadi MD
337 Westside Station Drive
Winchester, Virginia 22601
Phone: (540) 667-5400

*****Please note *if you are sending patient health records please fax immunization record ONLY and mail the remaining records to address above. Thank you.******

Child (Children's) Name	Date of Birth
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

Please be sure to list ALL children that you request to have records transferred for.

Parent or Guardian Signature: _____ Date: _____

Current Address: _____

Primary Phone Number: _____