Alphonsa M. Stephen M.D., F.A.A.P., P.C.
Southern Hills Pediatrics

5775 S. Fort Apache Rd., Suite 110
Las Vegas, NV 89148
Phone: (702) 450-0003
Fax: (702) 795-3306

Facility or Physician requesting medical records from:

Name:_____

Address:_____

_____

Phone:_____

Fax:_____

I, _____
authorize_____
to release my child/children's medical records (progress notes, immunization records, growth charts, lab results, and radiology reports) to Southern Hills Pediatrics, for continuing medical care.

Patient's Name:_____ D.O.B:_____

Patient's Name:_____ D.O.B:_____

Patient's Name:_____ D.O.B:_____

Patient's Name:_____ D.O.B:_____

Print Name of Parent or Guardian:_____

Signature of Parent or Guardian:_____

Today's Date:_____