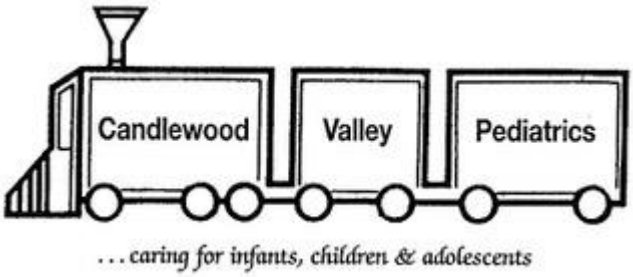

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MEDICAL RELEASE FORM

I authorize release of all medical records concerning

_____, DOB _____

to Candlewood Valley Pediatrics, ***FAX # 860-355-3856.***

Thank you.

_____ Date: _____
(Signature)

Relationship to Pt: _____

Contact phone number: _____

Previous Provider Name:_____ Fax Number: _____