RAINBOW PEDIATRICS
MEDICAL RECORDS REQUEST FORM

To:____

Address:____

Telephone Number:__________________ Fax Number:____________________

Patients Name:_______________________________ DOB:_________________

SSN:________________________ Telephone Number:_____________________

- ☐ Full Medical Record
- ☐ Immunization Record
- ☐ Physical Exams and Growth Charts
- ☐ Specified Item Requested____

Please drop off, mail or fax requested information to:

Rainbow Pediatrics
153 W. Main Street, Suite 200
New Albany, OH 43054
Phone: 614-939-2200
Fax: 614-939-2201

____ ___________________
Signature of Patient or Guarantor Date

***Please print, complete and forward to your child's previous physician prior to your first appointment in our office. Thank you.**