OSKIE PEDIATRICS

555 Knowles Drive, Suite 219
Los Gatos, CA 95032
(408) 378-6171

_____
date

Attention:
Dr._____
_____

_____
(address of medical facility)

I hereby request health information for:
Re:_____
(patient's name)

_____
(date of birth)

SCOPE OF ACCESS REQUESTED

I would like access to: ☐ All records including confidential psychological records if applicable ***or***

☐ The portion of records for the specified timeframe or concerning the problem noted:

_____

_____
(specify type of disease, accident, dates of treatment or other portions of records you are interested in)

TYPE OF ACCESS REQUESTED

☐ Please transfer all described records, to:

Lewis A. Osofsky, MD
555 Knowles Dr. Ste 219
Los Gatos, CA 95032
Fax(408) 378-0721

Thank you.

_____ _____
(signed) (date)

_____ ☐ parent of a minor patient
(print name) ☐ guardian of a minor patient

_____
_____
(address of parent or guardian)