Authorization of Medical Record Release

Patient Name: _____ Date of Birth: _____

Release Medical Records FROM:

Facility: _____

Address: _____

Phone #: _____

Fax #: _____

Disclose Medical Records To:

Facility: PM Pediatrics.

Address: 1412 W. Vine St, Kissimmee, FL

Phone #: (407)483-0672.

Fax #: (407)348-5882.

I Am Requesting Medical Records From Dates **From:** _____ **To:** _____

Please Send My Requested Information By:
☐ **Fax:** _____ ☐**Mail:**_____

☐**Picking-Up By:** _____
NOTE: It is preferred to send Records via Fax

I Authorize The Following Types Of Information To Be Released:

☐**All Medical Records**
☐**Labs/ Pathology/ Imaging**
☐**Immunizations**
☐**Medical History**
☐**Medications**
☐ **Hospital Docs**
☐ **Operative Notes**

Purpose Of Disclosure:

☐ **Referral to Specialist**
☐**Continuity of Treatment**
☐ **Personal Use**
☐ **Legal Investigation**

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Signature of Patient/ Parent/ Legal Guardian: _____

Print Name of Patient/ Parent/ Legal Guardian: _____

Date: _____

Relationship to Patient: _____