

South Florida Pediatric Partners

I HEREBY AUTHORIZE: South Florida Pediatric Partners

TO RELEASE MEDICAL /IMMUNIZATIONS RECORDS FOR:

Patient Name _____

Address _____

Date of Birth: _____ Phone: _____

Release to: Doctor/ Parent _____

Doctor/Parent Name: _____

Address: _____

Reason for Record Release: please check one

Moving _____ Over Age 21 _____ Your Own Records _____

Specialist Needs Records _____ Changing Insurance _____

Other (please explain) _____

Unhappy with Our Practice (please explain) _____

PLEASE NOTE: THERE IS A FEE OF \$1.00 PER PAGE FOR THE FIRST 25 PAGES AND .25 CENTS THEREAFTER.

_____ Entire Chart (fee)

_____ Immunizations & Growth Chart (no fee)

Signature _____ Date _____