South Florida Pediatric Partners

I HEARBY AUTHORIZE: South Florida Pediatric Partners

TO RELEASE MEDICAL /IMMUNIZATIONS RECORDS FOR:

Patient Name ______________________________

Address ______________________________

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Date of Birth: ______________ Phone: __________

Release to: Doctor/ Parent

Doctor/Parent Name: ______________________________

Address: ______________________________

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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