Pediatrics Plus of Central Florida, Inc.

1200 Sligh Blvd.
Orlando, Florida 32806
Phone: 407/859-7239 Fax: 407/850-9185

Authorization for Release of Medical Information

(Note: Each patient must have a separate release form)

Today's date: _____

Patient's Name: First _____ Last _____

Patient's date of birth: _____

I hereby release and authorize Pediatrics Plus to release the medical records of the dependent listed above (or of myself if I am over the age of 18years) including all diagnoses, treatments, prognoses, recommendations and all other data pertinent to the patient's treatment to the facility listed below. I hereby state that I am the child's parent or legal guardian (if patient is under the age of 18 years) and have the legal right to make and/or restrict healthcare decisions regarding the patient and that my parental authority to do so has not been terminated or restricted by the courts.

Are you transferring your child out of our practice?_____
If yes please give the reason_____
If no, what is the reason for needing records?_____

This request is being made for the following:
_____Complete records_____partial records_____, courtesy records

Fee for complete records: For the first 25 pages, the cost shall be $1.00 per page for the first 25 pages. For each page in excess of 25 pages, the cost shall be .25 cents per page. **We recommend that you make your own copy of these records to have available for future needs.**

Signature:_____Print name:_____

For release of HIV, Drug, Alcohol and/or Psychiatric information, an additional signature is required below

Signature:_____Print name:_____

_____Pick up records _____Mail records to address below

_____

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