

Pediatrics Plus of Central Florida, Inc.

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

REQUEST FOR MEDICAL RECORDS

Please release medical records from:

Please release records for the following children:

DOB:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Reason for transfer of records:

- Change in insurance Relocation (Moving) Changing Doctors Other

New Address and Telephone Number for Family:

Please mail the medical records to:

Pediatrics Plus of Central Florida, Inc
1200 Sligh Blvd.
Orlando, Florida 32806

I, _____, hereby authorize your facility to release any information, including the diagnosis, prognosis, treatment, and any pertinent information related to my child's healthcare for the dates of service with your practice.

Date: _____ Signature: _____

CONFIDENTIALITY NOTICE: The information contained in this facsimile transmission is privileged and confidential information intended for the use of the addressee shown above and should not be reviewed by any unauthorized person(s). Unauthorized disclosure, copying, distribution, or actions taken relying on the content of this information is strictly prohibited. IF YOU HAVE RECEIVED THIS FACSIMILE IN ERROR, PLEASE NOTIFY THE SENDER IMMEDIATELY BY CALLING: (615)790-3200. THANK YOU!