

# 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: \_\_\_\_\_

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