# 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:

1. _____ DOB:
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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