

REQUEST TO RELEASE MEDICAL RECORDS

PATIENT'S NAME: _____

DATE OF BIRTH: _____

I authorize and request that _____, release my
(doctor, practice, or hospital name)
child/children's complete medical records, for the Treatment Planning to include:

Please send us

1. Patient Encounter/ Well Visit Summary
2. Most Recent Well Visit- (If no well visit- please send Allergies, Family and Social History)
3. Most Recent Sick Visit- (Within the past 12 months)
4. Patient Problem List and Specialist Note(s) if Applicable
5. Medication List
6. Pregnancy/ Birth Records
7. Diagnostic Testing/ Labs (Within the past 2 years)
8. Psychiatric /Mental Health Notes if Applicable

To: **Peninsula Pediatrics of West Florida, PLLC.**

Steven Moore, MD

13131 66th St. North

Largo, FL 33773

Phone: 727-228-7000

Fax: 727-223-3614

1. I understand that authorizing the disclosure of this health information is voluntary and you have my consent to release medical records for all dates including all diagnostic tests of any type and reports, history, hospitalization, diagnosis, prognosis, treatment, medication and pharmacy records, correspondence, consults, statement of charges or expenses, and any and all reports of any type of character.
2. I understand that the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

This authorization will expire one year from the date signed. A copy or facsimile of this authorization shall be counted true and valid as original.

Signature of Patient or Legal Representative

Date

If signed by Legal Representative, Relationship to Patient