REQUEST TO RELEASE MEDICAL RECORDS

PATIENT'S NAME: _____

DATE OF BIRTH: _____

Previous Doctor: _____

Hospital: _____

I authorize and request that the above-named doctor/practice/hospital, release my child'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