1961 Floyd Street, Unit A
Sarasota, FL 34239
Phone: 941-955-7337 (PEDS)
Fax: 888-529-6332

Medical Records Release

I,_____ hereby authorize:
(Parent Name)

Good Pediatrics

To release the following medical records to: _____
(Practice Name)

Fax number / Email Address: _____

Concerning: _____ Date of Birth:_____
(Patient's Name)

_ _ All records	___ ECG/EEG/Cardiac Cath.	___ Operative Notes
___ Pathology Reports	___ Laboratory Reports	___ Radiology Reports
___ Emergency Reports	___ History & Physical	___ Progress Notes
___ Discharge Summary	___ Immunization record	___ Other:_____
		_____
		_____

Reason for Request:

__Transferring care ___Continuation of Care __Other:_____

Records include a summary of care, immunization records, growth charts and pertinent medical information specific to your child. By signing this authorization I give permission for my child's protected health information to be released to Good Pediatrics for the purpose of treatment. I understand that this authorization is in effect for one year from the date signed. I understand that I may cancel this request with written notification, but that it will not affect any information released prior to notification of cancellation

_____ _____
SIGNATURE Date

_____ _____
Printed Name of Parent/Guardian Relationship to Patient