



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

Medical Records Release To Good Pediatrics

I, _____ hereby authorize:
(Parent Name)

(Pediatric Practice)

to release the following medical records to **Good Pediatrics**, concerning:

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

☐ 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