Suncoast Pediatrics

# AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

**NAME OF PATIENT** (*Please Print*)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth** \_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize the release of Medical Records, excluding protected records as follows:

***Please Limit to the LAST 2 YEARS Information Only:***

* **Chart Notes/Medical Summary**
* **Immunization Records**
* **Growth Charts**
* **Laboratory and/or X-Ray Reports**
* **Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Records to be released from:**

#### Suncoast Pediatrics

### 1395 West Bay Drive

**Largo, Fl 33770**

**PH: (727) 584-6802**

**FAX :( 727) 586-6278**

TO REPRODUCE THE MEDICAL RECORDS OF THE PATIENT NAMED ABOVE

AND SUBMIT SUCH COPIES TO:

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

## REASON FOR REQUEST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SPECIAL REQUEST:** *(HIV TESTING-DRUG/ALCOHOL TESTING-PSYCHIATRIC*

*RECORDS will be released only if requested)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Of Parent/Legal Guardian ***(please print)*** Signature Of Parent/Legal Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient Date