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Professional Park Pediatrics

Medical Records Request

Patient Name: _____ Birth Date:_____

Patient Name: _____ Birth Date:_____

Patient Name: _____ Birth Date:_____

Patient Name: _____ Birth Date:_____

Patient Name: _____ Birth Date:_____

Requesting Medical Records From:
(Previous Doctor – Address/Phone #)

_____

_____

_____

Release Medical Records To:
(Dr. Martin/Dr. Elzie/Dr. Bunnell)

Professional Park Pediatrics

1881 Professional Park Circle Ste. 80

Tallahassee, Fl. 32308

Reason for Request of Records (Check One):
( ) Changing Doctors
( ) Moving
( ) Insurance Change
( ) Other – Please List:_____

Please release **ALL** medical records on file for the child(ren) listed above.

This authorization will expire twelve (12) months from the date signed below. I understand that this information is used or disclosed pursuant to this authorization, that it may be subject to re-disclosure by the recipient, and that it may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization unless the records have already been released.

_____ _____
Signature of Patient (18 or Older)/Parent (Under 18) Date

_____
Relationship to Patient (Parent/Self/Other Legal Guardian)

*******PLEASE DO NOT FAX RECORDS IF THERE ARE OVER 30 PAGES*******