## Pediatrics Plus of Central Florida, Inc.

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## Authorization for Release of Medical Information

(Note: Each patient must have a separate release form)

Today's date:	
Patient's Name: First	Last
Patient's date of birth:	
prognoses, recommendations and all other listed below. I hereby state that I am the age of 18 years) and have the legal right to	Plus to release the medical records of the dependent e age of 18 years) including all diagnoses, treatments, or data pertinent to the patient's treatment to the facili child's parent or legal guardian (if patient is under the to make and/or restrict healthcare decisions regarding to do so has not been terminated or restricted by the
Are you transferring your child out of If yes please give the reason If no, what is the reason for needing re	our practice?ecords?
This request is being made for the foll	
races pages. For each page in excess	t 25 pages, the cost shall be \$1.00 per page for the of 25 pages, the cost shall be .25 cents per page.  own copy of these records to have available for
Signature:	Print name:
For release of HIV, Drug, Alcohol and is required below	or Psychiatric information, an additional signature
Signature:	Print name:
Pick up records	Mail records to address below