Kids First Pediatric Care

Request for Medical Records:

Authorization to Disclose Protected Health Information

Patient Name:_____ **DOB:**_____ **Phone:** _____

Street Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Dear Dr._____ Date: _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone: _____ Fax: _____

The parent/ guardian of the above listed patient has asked us to request that the medical records be released and forwarded to our office.

In order for us to fully evaluate this patient's health and make informed decisions, the parent or guardian has approved our request for copies of all relevant records in your file. Please be sure to include office notes, immunization records, growth charts, X-ray reports, lab results, hospital records and consultation letters.

Thank you for expediting this request. Please send the records to our office at the address below.

SEND TO: KIDS FIRST PEDIATRIC CARE, PA
16301 FISHHAWK BLVD, SUITE 101
LITHIA, FL 33547-3932
Phone: 813-681-3800
FAX: 813-681-3883

I understand that the information in the health record may include information relating to sexually transmitted infections, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol or drug abuse.

I hereby authorize the release of all necessary medical records to KIDS FIRST PEDIATRIC CARE, PA. I understand that this form will expire **1 year** after signing, and that I may revoke/withdraw this authorization in writing to the office at any time.

Parent/ Guardian Signature _____ Date_____

Parent Address: _____

City: _____State: _____ ZIP Code: _____

Telephone Number: _____

Signature of Witness: _____