Medical Records Release Form

By signing this form, I authorize you to release confidential health information about the following patient(s) listed below, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the doctor office listed below:

Previous Primary Doctor Name: ______________________________

Address: ______________________________

Fax Number: ______________________________

Patient Name: ______________________________ **Date of Birth:** ______________

______________________________ ______________

______________________________ ______________

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The information you may release subject to this signed release form is as follows:

- ☐ Complete Records
- ☐ Care Plan
- ☐ Pathology Reports
- ☐ Hospital Reports
- ☐ History & Physical
- ☐ Lab Reports
- ☐ Treatment Record
- ☐ Medication Record
- ☐ Progress Notes
- ☐ Radiology Reports
- ☐ Operative Reports
- ☐ Other (please specify below)

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Release my protected health information to the following doctor office directly associated in my medical care:

Name: **Advanced Kid's Care**

Address: **98 Terra Mango Loop Unit 12, Orlando, FL 32835**

Signature:

______________________________ ______________________________

Parent or Guardian's Name Signature of Patient or Guardian

______________________________ ______________________________

Date Relationship to Patient(s)

ADVANCED
KIDS CARE

98 Terra Mango Loop
Unit 12
Orlando, Fl 32835
(407) 612-4007
(407) 612-4017 FAX
ABRPediatrics@gmail.com