RELEASE OF MEDICAL RECORDS AUTHORIZATION

Child's Name: ___________________________________ Date of Birth: ________________
(Print Name)
Child's Social Security #____

I hereby authorize and request **Sunshine Pediatrics of Central Florida, PL** to release my child's protected medical records to the following to the following:

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☐ **Immunization Records**	☐ **Growth Chart**
☐ **All Diagnostic Test Results**	☐ **Pathology/operative**
☐ **Therapy Records**	☐ **Other:** _____________________________
☐ **Complete Medical Records** (Note: If medical records contains Highly Confidential Records (e.g. HIV results, pregnancy, STD results) a separate release form needs to be completed.)	_____________________________________ _____________________________________ _____________________________________

Signature of Parent / Legal Guardian ____
Date_______________________________________
Daytime Phone Number _______________________

Intra- Office Transfer	**For Office Only**
From Site:______________________________ To Site:________________________________	Completed by:___________________________ Date Completed:_________________________

Sunshine Pediatrics of Central Florida, PL @ 2006