AUTHORIZATION FOR REQUEST OF MEDICAL RECORDS

I hereby authorize release of my child's (children's) Protected Medical records from:

_____

_____

_____

Release to:

Sunshine Pediatrics Of Central Florida
210 Lookout Place
Maitland, Fl. 32751
Phone (407) 215-0400 Fax (407) 215-0402

Child's Name: _____ Date of Birth: _____
(Print Name)
Social Security #_____

Child's Name: _____ Date of Birth: _____
(Print Name)
Social Security #_____

Child's Name: _____ Date of Birth: _____
(Print Name)
Social Security #_____

Child's Name: _____ Date of Birth: _____
(Print Name)
Social Security #_____

Child's Name: _____ Date of Birth: _____
(Print Name)
Social Security #_____

REQUESTING ALL OF THE FOLLOWING MEDICAL RECORDS

☐ **Complete Medical Records**	☐ **Psychological Reports/Evaluations Initial_____**
☐ **All Diagnostic Test Results**	☐ **Pathology/operative**
☐ **Therapy Records**	☐ **Other: _____**
☐ **Immunization Records/Growth Chart**	_____
	_____
	_____

Signature of Parent / Legal Guardian _____

Date_____

Daytime Phone Number _____