The Pediatric Center, Inc.

1447 MEDICAL PARK BLVD., SUITE #402
WELLINGTON, FL 33414
(561) 790-2600

10075 JOG ROAD, SUITE #308
BOYNTON BEACH, FL 33437
(561) 777-8419

927 S.E. 1ST STREET
BELLE GLADE, FL 33430
(561) 996-5252

CONSENT FOR RELEASE OF MEDICAL RECORDS

I hereby give consent to The Pediatric Center to release the medical records of my child(ren) to the person/doctor/facility listed below. This includes all information relating to psychiatric evaluations and/or care, drug/alcohol abuse, and the diagnosis and treatment of HIV or AIDS, when applicable.

I understand that only medical records originating from this office will be copied or sent. Records from all outside facilities are not property of this office and cannot be duplicated nor sent according to Florida statute 395.3025. I also understand if I require photocopies of any records, there will be a charge of $1.00 per page for the first 25 pages and 25 cents for each additional page thereafter. This is based on the Florida statute pertaining to medical records. If the records are in storage, there will be an additional charge of $30.

Child's Name:_____ D.O.B. _____
Child's Name:_____ D.O.B. _____
Child's Name:_____ D.O.B. _____
Child's Name:_____ D.O.B. _____

Release Records to:

Name of Person/Facility: _____
Address:_____
Phone Number:_____ Fax Number: _____

Records to be Released:

☐ Summary of medical records (including all significant medical history, shot records, etc.)

☐ Labs/Diagnostic Tests ☐ Immunization Records ☐ Entire chart (fees will apply)

☐ Other (please explain): _____

Reason for Release:

☐ Personal Release to Parent/Legal Guardian ☐ Insurance Change ☐ Moving out of Area

☐ Transfer to Adult Physician

☐ Dissatisfied with Practice: (Please explain): _____
_____
_____

Print Name of Parent/Legal Guardian: _____ Date: _____

Signature of Parent/Legal Guardian: _____ Date: _____