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

REQUEST FOR MEDICAL RECORDS

To:_____

Name of Dr./Facility we are obtaining medical records from

_____

Address

_____

Phone# Fax#

PLEASE RELEASE MEDICAL RECORDS TO:

___WELLINGTON OFFICE ___ BELLE GLADE OFFICE ___ BOYNTON OFFICE

FAX # 561-790-1535 FAX # 561-996-3330 FAX # 561-777-8426

_____

Parent/Guardian signature Date

_____

Patient's Name D.O.B.

_____

Patient's Name D.O.B.

By signing this form, I give permission for The Pediatric Center to receive any and all protected health information; necessary for the treatment of my son/daughter. This information may include but is not limited to office visit notes, labs, x-rays, consult letters, etc. I understand that this authorization can be revoked at anytime in writing.

Please release the following information:

____ Summary Sheet/Problem List
____ Laboratory Reports
____ Immunizations & Growth Charts
____ X-Ray/Imaging Reports
____ Consultations
____ Office Visits
____ E.R. Reports
____ Newborn Hospital Records
____ All medical information and reports