

Countryside Pediatric Care
2531 Landmark Dr.,Ste 103
Clearwater FL 33761
Phone: (727) 599-0893 Fax: (727) 674-2965

REQUEST FOR RELEASE OF MEDICAL RECORDS

TO: _____

I hereby authorize you to release medical records of:

My child's name is: _____
(Patient's full name) Date of birth _____

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(Patient's full name) Date of birth _____

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(Patient's full name) Date of birth _____

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(Patient's full name) Date of birth _____

Please mail medical records to: Countryside Pediatric Care
2531 Landmark Dr.,Ste 103
Clearwater FL 33761

Or Fax to: (727) 674-2965

Information Needed:

_____ All Records	_____ Medication List	_____ Radiology
_____ Newborn Discharge	_____ Consult Report	_____ Laboratory
_____ Hospital Discharge Summary	_____ Last Clinic Note	_____ Immunizations

Signature of Patient/Guardian Patient/Guardian Name Relationship to Patient Date

CONFIDENTIALITY NOTICE

The documents accompanying this fax transmission contain confidential information. The information is intended for the use of the individual named above. If you are not the intended recipient, you are notified that any disclosure, copying, distribution or the taking of any action in reliance on the contents of this information is not permissible. If you have received this fax in error, please immediately notify us by telephone at **(727) 599-0893** to arrange for the return of the original documents. Thank you for your cooperation.