AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

Countryside Pediatric Care
1840 Mease Drive, Suite 405
Safety Harbor, FL 34695
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

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

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

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

Please mail medical records to: Countryside Pediatric Care
1840 Mease dr., STE 405
Safety Harbor, FL 34695

Or Fax to: (727) 674-2965

Information Needed:

- ☐ **All Records**
- ☐ **Newborn Discharge**
- ☐ **Hospital Discharge Summary**
- ☐ **Medication List**
- ☐ **Consult Report**
- ☐ **Last Clinic Note**
- ☐ **Radiology**
- ☐ **Laboratory**
- ☐ **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.