Record Release Request

To Previous Doctor: _____

Child's Name: _____

Date of Birth: _____

Parent's Name/ Signature: _____

I request to have a copy of my child's entire medical record (including progress notes, labs, diagnostic studies, and any other information contained in my record)
Released to:

Gables Pediatrics

358 San Lorenzo Avenue # 3230

Coral Gables, Fl 33146

Phone: 305-444-6882

Fax: 305-441-9110

PLEASE ONLY SEND BY FAX THE IMMUNIZATION RECORDS AND THE LAST PHYSICAL. THE REST OF THE MEDICAL RECORDS MAIL IT TO THE ADDRESS ABOVE. THANK YOU!!!