3661 S Miami Ave
Suite 503
Miami, FL 33133
(786) 600-4PEDS (4733)
Fax: (786) 724-4889

MEDICAL RECORDS REQUEST

I, ____, the parent or legal guardian of the child(ren) listed below, do hereby request health information **from**:

____
(Clinic, Hospital, or Physician)

____ ________________________
(Address) (Telephone Number)

____ ________________________
(City, State, Zip Code) (Fax Number)

To be released **to**:

Marimón Pediatrics
3661 S Miami Ave, Suite 503
Miami, FL 33133
Fax: (786) 724-4889

Specifically, the information to be released is as follows (please include dates of admission, testing, or treatment, if applicable):

____

____

____

☐ The entire medical record for this patient ☐ Vaccination records only

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION:

By my signature below, I hereby authorize the use by or disclosure to Marimón Pediatrics of my individually identifiable health information as described above, as it pertains the following **children**. This authorization will expire on _____/_____/_________ (MO / DAY / YR) or otherwise will only be valid for 180 days after the date that my signature appears on this form. This authorization may be revoked by me at any time in writing, except to the extent that the records have already been obtained. Any re-disclosure of the information, depending on the nature of the information, may not be permitted without my specific authorization. I also understand that this authorization is voluntary. I understand that neither my care nor payment for my care will be affected if I choose not to sign this form.

CHILD'S FIRST NAME, MI, LAST NAME	SEX M	SEX F	DATE OF BIRTH MO / DAY / YR
1.____________________________	☐	☐	_____/_____/_________
2.____________________________	☐	☐	_____/_____/_________
3.____________________________	☐	☐	_____/_____/_________
4.____________________________	☐	☐	_____/_____/_________

X______________________________________ ______________________

Signature (Patient, Parent, or Guardian) Date