MEDICAL RECORDS REQUEST FORM

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

HOSPITAL, CLINIC, OR PHYSICIAN	
Name:	
Address:	
City, State & Zip:	
Phone:	Fax:

To be released **to**:

Marimón Pediatrics
3661 S Miami Ave, Suite 803
Miami, FL 33133
Phone: (786) 600-4733 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 and/or disclosure to Marimón Pediatrics of my individually identifiable health information as described above, as it pertains the following **children**. This authorization is only 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.

PATIENT INFORMATION		
Child 1:	**Sex:**	**Date of Birth:**
Child 2:	**Sex:**	**Date of Birth:**
Child 3:	**Sex:**	**Date of Birth:**
Child 4:	**Sex:**	**Date of Birth:**

SIGNATURE OF PARENT OR GUARDIAN

X ______________________________________ DATE: ______________________