RECORDS REQUEST

To: _____ *Date:* _____

Address: _____
Street

_____
City *State* *ZIP*

Phone: _____

Fax: _____

Requesting: _____

I hereby authorize the release of my daughter/son's medical records or copies of such, and request they are transferred to:

Perez-Grossman, LLC
1235 SW 87 Avenue, Miami, FL 33174
Tel. (305) 269-1990 Fax (305) 269-1970

Name of Patient: _____ *D.O.B:* _____

Parent / Guardian Information:

Name: _____

*Address:*_____
Street

_____
City *State* *ZIP*

_____.
Signature of Parent / Guardian

_____.
Relationship to Patient

For Office Use:

Request Completed By: _____ Date: ____/____/_____