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:

Shores Pediatrics

660 NE 95th Street, Suite A

Miami Shores, FL 33138

Phone: 305-757-8040

Fax: 305-757-8011

Please fax only the immunization records and most recent physical. All other medical records should be mailed to the address above.

Thank you!