Record Release Request

To: **Doctor's name / Hospital/ Facility** _____

Street Address, Tel, Fax: _____

RE: **Child's name**: _____

Date of birth: _____

_____

Parent's Printed Name/ Signature/ Today's date

_____

Witness printed name/ signature/ today's date

I expressly request to have a copy of my child's entire medical record (including progress notes, growth charts, immunizations, labs, diagnostic studies, therapy evaluations and any other information contained in my record), released to: (please circle appropriate physician) :

Ana M Hernandez-Puga, MD

9220 SW 72 ST, Suite 102

Miami, FL 33176

Phone: 305-275-1700

Fax: 1-888-569-3931