AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN BELOW.

I, _____, hereby voluntarily authorize the disclosure of information from my health record.
(Name of Patient)

Patient Name:_____ Record Number:_____

Patient's Date of Birth:_____ Patient's SSN:_____

Purpose of Release

- ☐ Change in insurance or Physician
- ☐ Continuation of Care
- ☐ Referral
- ☐ Other

Type of Information

- ☐ 2 years prior from last seen
- ☐ Complete Medical Record
- ☐ Dates Other: _____
- ☐ Specific Information Request

The Information is to be provided to:

Name of Person/Organization/Facility: SK Pediatrics – Lizaida Medina Candelaria, MD FAAP

Address: 9121 N. Military Trail Ste. 102, Palm Beach Gardens, FL 33410

Phone Number: 561-619-2460

Fax Number: 844-886-3192

_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

Under HIPAA with patients' written request, records must be provided within 30 days of a request.
Under House Bill 300 Texas Law with patient's written request, records must be provided within 15 days of a request.