AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

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

I hereby voluntarily authorize and request the disclosure of all information which you may possess relating to my examination and illness, including psychiatric, psychological information and information pertaining to AIDS, Human Immune Deficiency Virus Testing and any other medical problem which may be part of my medical records, covering the periods from birth to present.

Purpose of Release

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

Type of Information

- ✓ Complete Medical Record
- ☐ Specific Information Request: _____

The Information is to be provided to:

Name Organization/Facility:	**SuperKids Pediatrics**
Address:	9121 N. Military Trail Ste. 102, Palm Beach Gardens, FL 33410
Phone Number:	561-619-2460
Fax Number:	**844-886-3192**

_____ _____

Patient's Guardian Signature Date

_____ _____

Printed Name of Patient's Guardian Relationship to Patient