

REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____

(NAME, ADDRESS, PHONE)

Please forward all medical records (including “PHI” as defined by HIPPA) for all children listed below to:

TLC Pediatric & Adolescent Medicine, P.A.
11715 Orpington St., Suite A
Orlando, FL 32817

(PRINT NAME: parent/legal guardian)

(parent/legal guardian signature)

(date)

Children: (note: if these are newborn records, include mother’s name and DOB)

Name

DOB

