LONGWOOD PEDIATRICS
1400 W SR 434, # 1010
LONGWOOD FL 32750

Records Release Authorization

Parent / Legal Guardian Name:	
Child's Name	Date of Birth
Child's Name	Date of Birth
Child's Name	Date of Birth

The Parent/Legal Guardian authorizes and requests LONGWOOD PEDIATRICS (check one):

☐ Release to____

☐ Obtain from____

Please release following medical information (check one)

☐ All medical records

☐ Immunization records and last physical exam notes

The purpose of releasing this information:

☐ Changing Insurance ☐ Moving ☐ Other

My signature below indicates that I understand what information will be released and the need for that information. I further understand that the information to be released may include information regarding drug and alcohol abuse or AIDS/HIV. In addition, information related to drug and alcohol abuse in my child's records is protected under federal regulations and cannot be released without my written consent unless otherwise provided in the 42 Code of Federal Regulations Part 2.

____
Parent / Legal Guardian Signature

____
Relationship

____
Date

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