Plantation Office
220 S.W. 84th Avenue
Suite 206
Plantation, FL 33324
(954) 423-2300

WEST BROWARD PEDIATRICS

Weston Office
1040 Weston Road
Suite 310
Weston, FL 33326
(954) 384-8885

RECORDS RELEASE AUTHORIZATION

ATTENTION: MEDICAL RECORDS DEPARTMENT

Name of Previous Physician: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

E-mail: _____

I authorize and request you to release the following records for my Child/Children listed below to West Broward Pediatrics via e-mail **OR** fax below:

E-mail Address: Records@WestBrowardPediatrics.com

OR

Fax Number: (954) 424-4200

* Problem List
* Last Two Well Exams
* Last Two Sick Visits
* Growth Chart
* Full Immunization Record

* For Children six months of age and younger, please provide all records

_____ **I DO authorize** release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

_____ **I DO NOT authorize** release of information related to AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse.

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

_____ _____
Child's Name Date of Birth

Name of Parent or Legal Guardian: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____

Signature of Parent/Legal Guardian: _____ Date: _____

Printed Name of Parent/Legal Guardian: _____

Witness: _____ Date: _____