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

Date: ____

RECORDS RELEASE AUTHORIZATION - <u>SPECIALIST</u> ATTENTION: MEDICAL RECORDS DEPARTMENT

Address:			
City:	Sta	ate:	Zip Code:
Phone:	Fax:		
E-mail:			
Please forward my child's records to West Broward F	Pediatrics by e-mail <u>OR</u>	ax below:	
E-mail Address: Records@WestBrowardPediatric OR Fax Number: (954) 424-4200	cs.com		
I authorize and request you to release the following r	records:		
I DO authorize release of information related or HIV (Human Immunodeficiency Virus) infection, ps			
	sychiatric care and/or ps elated to AIDS (Acquired	ychological Immunode	assessment, and eficiency Syndrome
or HIV (Human Immunodeficiency Virus) infection, pstreatment for alcohol and/or drug abuse. I DO NOT authorize release of information reformed or HIV (Human Immunodeficiency Virus) infection, ptreatment for alcohol and/or drug abuse.	sychiatric care and/or ps elated to AIDS (Acquired	ychological Immunode sychologica	assessment, and eficiency Syndrome
or HIV (Human Immunodeficiency Virus) infection, pstreatment for alcohol and/or drug abuse. I DO NOT authorize release of information reformed or HIV (Human Immunodeficiency Virus) infection, ptreatment for alcohol and/or drug abuse. Child's Name	sychiatric care and/or pselated to AIDS (Acquired psychiatric care and/or psyc	ychological Immunode sychologica	assessment, and eficiency Syndrome lassessment, and
or HIV (Human Immunodeficiency Virus) infection, pstreatment for alcohol and/or drug abuse. I DO NOT authorize release of information reformed or HIV (Human Immunodeficiency Virus) infection, ptreatment for alcohol and/or drug abuse. Child's Name ame of Parent or Legal Guardian:	sychiatric care and/or pselated to AIDS (Acquired psychiatric care and/or psychiatric care	ychological Immunode sychologica	assessment, and eficiency Syndrome lassessment, and
or HIV (Human Immunodeficiency Virus) infection, pstreatment for alcohol and/or drug abuse. I DO NOT authorize release of information reformed or HIV (Human Immunodeficiency Virus) infection, ptreatment for alcohol and/or drug abuse. Child's Name Iame of Parent or Legal Guardian:	elated to AIDS (Acquired elated to AIDS (Acquired elated to AIDS)	ychological Immunode sychologica	assessment, and eficiency Syndrome I assessment, and
or HIV (Human Immunodeficiency Virus) infection, postreatment for alcohol and/or drug abuse. I DO NOT authorize release of information reformed or HIV (Human Immunodeficiency Virus) infection, postreatment for alcohol and/or drug abuse. Child's Name Iame of Parent or Legal Guardian: City:	elated to AIDS (Acquired psychiatric care and/or psych	ychological Immunode sychologica Da	assessment, and eficiency Syndrome l assessment, and te of Birth Code:
or HIV (Human Immunodeficiency Virus) infection, pstreatment for alcohol and/or drug abuse. I DO NOT authorize release of information reor HIV (Human Immunodeficiency Virus) infection, p	elated to AIDS (Acquired psychiatric care and/or psych	ychological Immunode sychologica Da	assessment, and eficiency Syndrome l assessment, and te of Birth Code: