Capote Pediatrics

6995 Professional Pkwy E. Unit C
Sarasota, FL 34240
Phone (941) 355-9374 Fax (941) 355-9379

MEDICAL RECORD RELEASE

I, _____, the parent/guardian for

_____, hereby request and authorize
Patient Name Date of Birth

Capote Pediatrics to obtain medical records **from** OR provide records **to:**

_____
Facility Name Facility Fax

I am requesting following medical information to be released:

[ ] All Medical information and reports
[ ] Specific information:_____
[ ] Labs only
[ ] Immunization records only

Information I do not want released:_____

All information I authorize to be obtained from this agency will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that Florida Law requires this request to be processed within 30 days of receipt of this notice.

_____
Signature of Parent/Guardian Date