CONSENT FOR RELEASE OF INFORMATION

Patient Name: _____ DOB: _____

Parent or Guardian: _____

I give permission for my (my child's) Medical Records To be released from :

Facility: _____

_____

TO: Surfside Pediatrics
325 5th Avenue, Suite 203
Indialantic, Florida 32903
Phone: 321-821-4882 Fax: 321-312-4598

These Medical Records are required for the continuing treatment of this patient and will be used in accordance with this facilities established Privacy Practices.

Specific Records required:_____

_____

_____

I understand that this authorization is voluntary, and that I may revoke this authorization in writing at any time. I also understand that this signed consent will be valid for one year from the date indicated below.

Signed: _____ Date: _____

Print Name: _____