407 Wekiva Springs Road
Suite 110
Longwood, FL 32779

407-790-7998
407-951-8821 (F)

Authorization- for records release/request of confidential information

- **This is to request and authorize you to release to Wekiva Springs Pediatrics**
- **I hereby authorize Wekiva Springs Pediatrics to release to:**

_____

Physician

_____

Address

_____

Phone **Fax**

I understand and direct that this authorization remain effective for 120 days or until I revoke it in writing. I hereby release **Wekiva Springs Pediatrics** its employees from any and all liability that may arise from the release of this information as I have directed.

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by law. Any further re-disclosure is strictly prohibited.

** PLEASE RELEASE MY MEDICAL RECORDS***

Initial by the item you want to have release

State period of time: From _____to _____.

___1.All Medical records (includes#2-#9)	___5. Laboratory results
___ 2. Immunization Records	___6. X-ray Report
___3.Consultation	___7. ER records
___4. Surgical reports	___8. Newborn/ birth records

_____ ____

_____

Patient Name Date of Birth

407 Wekiva Springs Road
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Longwood, FL 32779

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_____

_____

Patient signature /Parent or Guardian

Date of authorization