Baldwin Pediatrics

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Request for Obtaining Medical Records

Patient's Name :_____ Date of Birth:_____

I hereby authorize (previous Doctor's office) :_____

Phone Number :_____

Fax/Mail all or portion health information relating to my child's care to the physician or entity named.

- If only releasing a portion of the records, please specify information requested:

_____

To: Baldwin Pediatrics 528 W. Baldwin Rd. Panama City, FL. 32405
Please include this page as a cover sheet when faxing back records.

Reason for records request:
☐ Moving ☐ Changing Physicians ☐ Temporary Release

I understand that the information in my health record may include information relating to sexually transmitted diseases, AIDS, or HIV. It may include information about behavioral or mental health services ans treatment for alcohol and drug abuse. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Baldwin Pediatrics. The revocation will not apply to information that has already been released to this authorization. By signing, I understand that I am confirming my authorization for release and use of these medical records by Baldwin Pediatrics. Unless otherwise revoked, these authorizations will expire_____.

Parent/ Guardian Signature: _____

Print Parent/ Guardian Name: _____

Date: _____ ☐ Mother ☐ Father ☐ Guardian