ACD Pediatric Group

Record released authorization form

To: _____

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To Whom It May Concern:

Re: _____ DOB: _____

This authorizes the physician to furnish full and complete medical records and information hereby requested by the undersigned to "ACD Pediatric Group". This includes all medical reports and x-rays concerning any and all medical treatment rendered to the patient at this time.

You are requested to disclose no information to any other persons without written authority to do so.

All prior authorizations are hereby cancelled.

_____ _____ _____

Signature of patient or Guardian if minor Print name Relation

_____

Date

3416 W 84 St. Ste 100. Hialeah Gardens, FL. 33018 Ph: 305-828-1255 Fax: 305-828-1255