MEDICAL RECORD RELEASE

Date of Request: _____

To: _____

_____

_____

_____

I authorize the release of medical records to:

Kidsville Pediatrics, LLC

1050 W Carroll St.

Suite B

Kissimmee, Florida 34741

ATTENTION: Dr._____

Patient Name: _____ Date of Birth: _____

_____ Date of Birth: _____

_____ Date of Birth: _____

_____ Date of Birth: _____

Requested By: _____ Relationship: _____

Patient/ Parent/ Legal Guardian Signature: _____

(Patient if over 18 years old)

Home phone number: _____ Work phone number: _____