My Children's Doctor, PA

2484 Caring Way Ste F

Port Charlotte, FL 33952

Phone: (941) 625-1999

Fax: (941) 625-4600

I, _____, authorize Dr. Luis R. Rodriguez to:

□ Send my medical records to: □ Obtain my medical records from:

Name: _____

Address: _____

Phone # / Fax #: _____

□ Medical records (except as authorized by law, release of HIV/AIDS or alcohol/drug related information will require a specific release form).

□ Medical records including HIV/AIDS, alcohol related information.

□ I am transferring to this doctor (free of charge).

□ I am not transferring care, but just want someone else to know about my care.

□ I am requesting these records to be released to myself. Upon receipt I release Dr. Luis Rodriguez of any or all legal responsibility from this date forward. (Release of these records will result in a charge of $1.00 per page).

This release applies to:

Name (please print)	**Birth Date**	**Relationship to Patient**

A photo static copy of this release is as valid as he original. I understand that I may withdraw consent at any time.

Name: _____

Signed: _____ **Date:** _____

Witness: _____ **Date:** _____

FOR OFFICE USE ONLY:

These records were mailed / faxed on _____ by _____