North Naples Pediatric Center

REQUEST/AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Old Doctor Name, address:

_____

_____

_____

Tel: _____ Fax: _____

This letter represents my written authorization and request to release all medical records including any records relating to HIV and other sexually transmitted diseases, drugs/alcohol abuse, mental illness or psychiatric treatment. This authorization and request of transfer of medical records also releases North Naples Pediatric Center and all of their staff members from any and all legal responsibilities. This authorization and request is only limited to the child/children listed below:

NAME: _____ **D/O/B** _____

NAME: _____ **D/O/B** _____

NAME: _____ **D/O/B** _____

NAME: _____ **D/O/B** _____

NAME: _____ **D/O/B** _____

PLEASE MAIL MEDICAL RECORDS TO:

Dina A. Badra, M.D., F.A.A.P.
North Naples Pediatric Center
9160 Galleria Court
Naples, FL 34109

Signature of Parent/Guardian: _____ **Date:** _____

Name of Parent/Guardian: _____

Reason for the request for medical records: _____

W/doc. Online Med. Rel.