Records Release Request

I hereby authorize the release of my medical records or copies of such and request that they be transferred upon receipt of this request.

To/From (circle one)	Patients Name:_____
Name:_____	DOB: ___/___/_____
Address:_____	Please include: (circle each needed)
City:_____ State:_____	Immunizations Medication List
Zip:_____ Phone:_____	Labs All providers notes

My child's protected health information will be used by or disclosed to the person as indicated on this request for the following reason:

- ☐ Child is transferring due to age
- ☐ Moving
- ☐ Personal Use
- ☐ Second Opinion
- ☐ I am dissatisfied with this practice. Please Explain: _____

_____

_____

Please provide your mailing address if you would like us to mail your medical records to you.

_____

_____

_____

Special Instructions: _____

_____

I have read and understand the above statements and consent to the release as described.

_____ _____ ____/____/____

Print Parent/Legal guardian name Signature Date

Oceanside Pediatrics • 1370 13th Ave. South Suite 216 • Jacksonville Beach, FL 32250 • (904) 246-0644 • fax (904) 246-8578
Dr. Barbara O'Reilly • Dr. Elena Model • Dr. Ann Vonthron • Shannon Frazier Miller, ARNP