Naples Pediatrics, Inc
Katarina E. Ondrejicka, M.D.
Paul R. Irra, M.D.
5400 Park Central Ct.
Naples, FL 34109
(239) 593-7000
(239) 593-7008 Fax

REQUEST FOR MEDICAL RECORDS

Medical Release of Records From:

_____
_____
_____

I _____ hereby authorize the release of any and all the medical records for my child/children to **NAPLES PEDIATRICS**. Including any and all HIV and AIDS records, alcohol and drug abuse records and psychiatric and psychotherapeutic records for the child/children listed below. The purpose of this release of records is for:

____Continuity of Care ____ School Entry ____ Legal ____ Disablity

____ Other: _____

_____ _____
(Minor Child) (Date of Birth)

_____ _____
(Minor Child) (Date of Birth)

_____ _____
(Minor Child) (Date of Birth)

I understand that I have the right to revoke this authorization at any time; otherwise this authorization will expire in 90 days from the date listed below. I do hereby agree to hold said Naples Pediatrics, its agents and staff members free and harmless from any actions against it or them for alleged invasion of privacy, liable or slander, or defamation, arising in connection with disclosure of such information.

I have read this authorization and understand it.

_____
Parent/Guardian Date

_____
Relationship to child/children

Request to revoke this authorization prior to the 90 days must be sent in writing to Naples Pediatrics Inc, 5400 Park Central Ct, Suite 2, Naples, FL 34109