MEDICAL RECORD RELEASE FORM

EAST POMPANO PEDIATRICS, PA
601 EAST SAMPLE ROAD STE.107
POMPANO BEACH, FL 33064
(954)785-2355
(954)785-0755 FAX

PATIENT NAME:____

ADDRESS:____

DATE OF BIRTH:____

I HEREBY AUTHORIZE THE RELEASE OF MY CHILD'S HEALTH INFORMATION (MEDICAL RECORDS) AS INDICATED BELOW.

THIS INFORMATION IS TO BE RELEASED TO: (PLEASE CIRCLE DESTINATION)

1. EAST POMPANO PEDIATRICS, PA
HARRY JEAN-BAPTISTE, MD
GEMINA RAMEAU, APRN

2. OTHER: PLEASE FILL IN:

NAME:__________________________________

ADDRESS:________________________________

PHONE/FAX:______________________________

I UNDERSTAND AND AUTHORIZE THE USE OF THIS MEDICAL RELEASE FORM.

NAME:____
PARENT/GUARDIAN

SIGNATURE:________________________________ DATE:____________