REQUEST FOR MEDICAL RECORDS

TO DR.: _____

Phone #: _____ FAX #: _____

I, undersigned, hereby authorize **ALL BETTER PEDIATRIC GROUP** to request the following information from my (relationship) _____ medical records. This authorization includes release of information concerning HIV testing or treatment of AIDS, AIDS-related conditions, drug or alcohol abuse, and drug related conditions, alcoholism, and/ or psychiatric/psychological conditions.

The following information may be release or reviewed:

__ DISCHARGE SUMMARY
_X_ HISTORY & PHYSICAL EXAMINATION
__ OPERATIVE REPORT
__ OUTPATIENT CLINIC NOTES
_X_ IMMUNIZATION (SHOT) RECORDS
__ EMERGENCY DEPARTMENT RECORDS
_X_ ALL RECORDS AND IMMUNIZATION RECORDS, PLEASE..!!

THE ABOVE INFORMATION IS TO BE RELEASED TO:

ALL BETTER PEDIATRIC GROUP
5300 WEST HILLSBORO BLDV, SUITE 110
COCONUT CREEK, FL 33073
Phone: (954) 794-1360 Fax: (954)794-1367

The above information is requested to be release for the following purposes only

CHANGE OF PRIMARY CARE PHYSICIAN

This statement must be signed and dated, and may be revoked at any time except in the extent action has been taken prior to revocation. This consent will expire (60) days after the date below, or sooner by my choice.

I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of treatment records to the purpose and extent stated above.

PATIENT'S NAME:_____**D.O.B.:**_____
ADDRESS: _____

_____

SIGNATURE:_____ RELATIONSHIP: _____

PHONE #.: _____ DATE: _____

* LEGAL GUARDIAN OF PATIENT MUST SIGN THE AUTHORIZATION BECAUSE HE/SHE IS AN EMANCIPATED MINOR OR THE CONDITIONS OF TREATMENT REQUIRE SIGNATURE.