GARDENS PEDIATRICS
500 University Blvd. Suite – 102
Jupiter, FL 33458

PH:561-622-6610 FAX:561-622-6091

MEDICAL RECORDS RELEASE FORM

CHILD'S NAME _____***Date of Birth:*** _____

I _____ , authorize Dr. _____

_____ to release my son's / Daughter's

Medical records to Dr. Gowda at Gardens Pediatrics.

Date: _____

_____
Parent / Guardian

Previous Pediatrician's Information

_____

_____

_____

Ph: _____ Fax: _____