Tree House Pediatrics
10743 Narcoossee Road Suite A13
Orlando, Florida 32832
407-736-8733 Fax 407-736-8669

Authorization for release of protected health information to above listed medical facility

Patient: _____ Date of Birth:_____

Address: _____

City, State, Zip Code:_____

Information requested from:
Doctor_____
Address:_____
City, State, Zip Code: _____
Phone Number: _____
(Phone number or address are greatly appreciated)

Information to be disclosed (please specify with a check mark)

____ Shot Records _____ Growth Charts

____ 3 previous office visits _____ Most recent physical exam

____ Entire record (if your child has complex medical issues)

Purpose of Disclosure (please circle)

Further medical care Changing physicians Personal Copy

This authorization for release of health information will be valid for one calendar year from the date of signature. It may be revoked at any time in writing.

Parent/Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____