



Dr. Martinez-Rubio, Pediatric Endocrinologist

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MEDICAL RECORD REQUEST FORM

Patient Name: _____

Date of Birth: _____

I hereby authorize the below listed entity to release medical information to **Little Palms Endocrinology & Diabetes Center**. Request my records from:

Name: _____

Phone: _____

Address: _____

Fax: _____

Medical Information Requested:

- All Records
- Specific Records from _____ to _____ (dates)
- Laboratory Results
- Radiology Results (X-ray, Ultrasound, CT, MRI, etc.)

I hereby authorize the use of disclosure of my individually identifiable health information as described. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment, or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be re-disclosed and may no longer be protected by federal privacy regulations. Therefore, I release **Little Palms Pediatric Endocrine & Diabetes Center** from all liability arising from this disclosure of my health information.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Signature of Patient or Parent/Legal Guardian

Today's Date