



Dr. Martinez-Rubio, Pediatric Endocrinologist

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MEDICAL RECORD RELEASE FORM

Patient Name: _____

Date of Birth: _____

I hereby authorize **Little Palms Endocrinology & Diabetes Center** to release my medical records to:

Name: _____

Phone: _____

Address: _____

Fax: _____

Please indicate the purpose of this authorization:

- Personal
- Changing Physicians
- Legal Investigation or Action
- Disclosure to a third-party
- Other

Medical Information Requested:

- All Records
- Last Visit Record
- Laboratory Results
- Radiology Results (X-ray, Ultrasound, CT, MRI, etc.)
- Other

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 (if minor)

Today's Date