

WILSON PEDIATRICS



Records Release To Wilson Pediatrics (Transfer in)

If you have any difficulties obtaining your records, please contact our front desk staff.

Parent or Guardian: _____

Address: _____ City _____ St _____ Zip: _____

Cell#: _____ Work# _____ Home Phone# _____

Email: _____

Children's Names:

1. _____ DOB: _____

2. _____ DOB: _____

3. _____ DOB: _____

I authorize: (Name of previous physician) _____

Phone: _____ Fax: _____

to release medical information from my medical record to:

WILSON PEDIATRICS 2940

Immokalee Road, Suite #2

Naples , FL 34110-1409

(239) 598-5750

Fax#: (239) 593-1989

for the purpose of review/examination. I further authorize you to provide copies as requested and indicated to the limitations below:

Substance Abuse Yes: No:

Psychiatric/Mental Health Information Yes: No:

HIV Information Yes: No:

This authorization will automatically expire on year from the date signed.

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon.

Signed: _____ Date: _____

OFFICE USE ONLY

Date Received: _____ Records Sent By: _____ Date _____