**REQUEST FOR MEDICAL RECORD**
**KIDS KLINIC**
**114 SE 20th AVE**
**POMPANO BEACH, FL 33060**
**(954) 943-7638 x 100  FAX (954) 943-5950**

**PATIENT NAME: _____**

**ADDRESS: _____**

**DATE OF BIRTH: _____**

**"I hereby authorize the release of my child's health information (information about my child's medical records) as indicated below."**

**DESCRIPTION OF INFORMATION TO DISCLOSE: _____**

**_____**

**I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE USE OF THIS AUTHORIZATION.**

**SIGNATURE: _____DATE: _____**
**PARENT/GUARDIAN**