Children's Health of Ocala

Thank you for choosing our office! In order to serve you properly, we need the following information. Please print. All information will be confidential.

Medical Record Transfer For

hereby authorize

I ,_____ _____

Parent/Guardian Name — Name of Doctor, Practice or Clinic

_____ _____

Address — Office Address

_____ _____

City, State Zip — City, State Zip

_____ _____

Phone — Phone **Fax**

To release my child(ren)'s medical records to:

☐ Children's Health of Ocala
1301 SE 25th Loop
Ocala, Fl. 34471
Tel (352) 671-1800 • Fax (352) 671-1802

Patient Information:

1._____ 2._____

Name D.O.B — Name D.O.B

3._____ 4._____

Name D.O.B — Name D.O.B

I understand that this information may contain psychiatric, drug and alcohol treatment, HIV/AIDS testing and status, sexually transmitted disease diagnosis and other sensitive medical information of either my children, myself or my child(ren)s' other parent. I agree to hold Children's Health of Ocala harmless from any and all costs, liability and damages of any nature resulting directly or indirectly from the release of my child(ren)s' medical records.

_____ _____

Signature of Parent /Guardian — Date