NIGHT LITE PEDIATRICS URGENT CARE
5900 S. JOHN YOUNG PKWY
ORLANDO, FLORIDA 32839
PHONE: 407-398-6470 FAX: 407-894-6872

Patient Name: ____ **DOB:** _______________________________

Current Phone: ____

Current Address: ____

RELEASE MEDICAL RECORDS FROM:

Name or Facility: _________________________________

Address: ____

Phone: _________________ **Fax:** __________________

DISCLOSE MEDICAL RECORDS TO:

Name or Facility: ___________________________________

Address: ____

Phone: ___________________ **Fax:** _____________________

____ **Please release complete medical records unless otherwise specified below:**
From ________________ **To** _____________________

Please send my requested information by:
☐ **Fax:** __________________ ☐ **Mail:** ____________________ ☐ **Email:** ______________________________
NOTE: It is preferred to send records via fax. ☐ **Patient Portal**

I authorize the following types of information to be released:

- ☐ All Medical Records
- ☐ Labs/Pathology/X-rays
- ☐ Immunizations/Vaccines
- ☐ History/Physicals
- ☐ Special Consultations
- ☐ Hospital Records
- ☐ Operative Notes
- ☐ Growth Charts
- ☐ Medications
- ☐ Photos
- ☐ Billing Statements
- ☐ Other: COVID-19

Your initials are required to release the following:
______ Psychiatric/Psychological Evaluations and Notes
______ Drugs/Alcohol Results
______ HIV/STD Report

*If Requesting Adolescent Encounters Minor Must Sign:

____

Purpose of Disclosure: (Please Specify):

- ☐ Transfer of Care
- ☐ Continuity of Treatment
- ☐ Personal Use
- ☐ Other: ______________________

Expiration Date: _______________________________
*If left blank, this authorization will expire one year from the

***I further agree that no person, firm or cooperation shall be held liable in any manner for furnishing or having furnished such information. Should I request records for my own personal use I will be charged according to Florida Statute 64B8-10.003 the cost of reproducing ALL medical records of $1.00 per page for the first 25 pages and an excess of 25 cents thereafter. I understand and direct this authorization will remain in effect for (12) months or until I revoke it in writing.**

Print Name of Patient/Parent/Legal Guardian: ____

Signature of Patient/Parent/Legal Guardian: ____

Date: _________________________________

Relationship to Patient: _______________________________

Witness: ___________________________________