



Cordero, Perez-Silva & Rodriguez, MD PA

2700 SW 3 Avenue, Suite 1-F
Miami, Florida 33129
Tel: (305) 285-2574
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MEDICAL RECORD REQUEST

I, _____, being the parent or legal guardian of the child below, do hereby request:

Clinic/Hospital or Physician Name

Address

City, State, Zip code

Phone Number

To release medical records specified below to:

Cordero, Perez-Silva & Rodriguez, PA
2700 SW Third Avenue, Suite 1-F, Miami, Florida 33129

The specific information to be released is as follows:

_____ Entire patient record

_____ Immunization Records Only

_____ X-ray Only (Specify) _____

_____ Outpatient/Inpatient Records (Specify) _____

_____ Emergency Room Record (Specify Dates) _____

_____ All Record Relating to (Specify) _____

This authorization is only valid for 60 days after my signature appears on this form. This authorization may be revoked by me at any time except to the extent that the records have already been obtained. Any re-disclosure of the information, depending on the nature of the information, may not be permitted without my specific authorization.

Patient Name

DOB

Signature of Patient, Parent, or Guardian

Date