Office: 407-483-5900
Fax: 407-483-5902

1136 Cypress Glen Circle
Kissimmee, Fl 34741

Dr. Sanjay Mehra

Medical Release

I, ______________________________ (**Parent**/**Legal Guardian**), hereby authorize Loop Pediatrics to:

____ Release Copies of the medical records of my child

____ (**Patient name, DOB, and SSN**) to:

____ Obtain copies of the medical records of my child

____ (**Patient name, DOB, and SSN**) from:

____
Name of Facility and/or Physician

____
Address

____
City State Zip

THE FOLLOWING:

- ☐ Hospital records including Hx & Phys and Discharge Summaries from the dates: ____________ to ___________
- ☐ Emergency Room Notes from the period: ____________ to ___________
- ☐ Diagnostic Tests and Labs
- ☐ Immunization Records (Please fax Immunization Records, All other requested records may be sent by mail)
- ☐ Office Notes from this period: _____________ to _____________
- ☐ Complete Medical Record

PURPOSE OF DISCLOSURE:

- ☐ Referral to Specialist
- ☐ Change of Physician
- ☐ Continuing Care
- ☐ Insurance
- ☐ Workers Comp
- ☐ Personal
- ☐ Legal Investigation
- ☐ Disability Determination/SSI
- ☐ Other, Please specify: _________________________

INFORMATION TO BE EXCLUDED, NOT RELEASED:

- ☐ Mental Health Records
- ☐ HIV Testing
- ☐ Drug Alcohol Treatment
- ☐ Sexual Assault/ Victimization Records
- ☐ Other, please specify: ____

I hereby authorize disclosure of the health information for the above name patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is furnished may not condition its treatment of me on whether or not I sign the authorization.

______________________________ ____________________________________ ______________
SIGNATURE OF PARENT/LEGAL GUARDIAN RELATION TO PATIENT DATE

PLEASE MAIL THE RECORDS IF MORE THAN 20 PAGES