

I hereby authorize and request **Medical Records** to/from:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Dr. Cannizzaro\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Previous Pediatrician

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_357 Wekiva Springs Rd.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address

\_\_\_\_\_\_\_321-280-5867\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_407-774-1877\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number Fax Number

Please release the complete medical records of the following Patient:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name D.O.B

Please send **medical records** to (mark which box):

 **× Cannizzaro Integrative Pediatric Center**

 **357 Wekiva Springs Rd.**

 **Longwood, FL 32779**

**321-280-5867 (Main)** **407-774-1877 (Fax)**

 **or**

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Previous Pediatrician

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number Fax Number

Joseph A Cannizzaro M.D.

Deborah Wills ARNP

Lauren Meador PA-C

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Legal guardian Date