** Transfer of Medical Records Authorization**

PATIENT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please send information, including diagnosis and records of any treatment or examination rendered.

Por Favor de enviar informacion de diagnosis y record de todo tratamiento o examen realizado.

TO: L&J Pediatrics, PA  FROM: L&J Pediatrics, PA

20338 NW 2nd Ave 20338 NW 2nd Ave

Miami, FL 33169 Miami, FL 33169

Phone: 305-770-1937 Phone: 305-770-1937

Fax: 305-770-1468 Fax: 305-770-1468

From: To:

I hereby authorize you to release information including the diagnosis and records of any treatment or examination rendered to L&J Pediatrics, Pa. I am aware that the records released may contain information relating to physical testing, physical abuse, or drug and/or alcohol abuse.

He aqui doy mi autorizacion para la transferencia de informacion medica, inclusive el diagnosis y record de todo tratameinto o examen relizado, a L&J Pediatrics, PA. Reconozco que es posible que la record transferida contiene informacion prueba fisica, abuso fisico, o abuso de drogas o de alcohol.

Parent/Guardian Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_