RDV SPORTSPLEX Pediatrics
8701 Maitland Summit Blvd
Orlando, FL 32810
Phone: 407-916-4520 ✦ Fax: 407-916-4525

Authorization to Obtain Medical Records

I authorize RDV Sportsplex Pediatrics to **OBTAIN** the entire medical record of my child(ren).

Name of Parent/Legal Guardian: _____

Relationship to child(ren): _____

Parent/Legal Guardian Phone Number: ( ) _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Obtain Medical Records from:

Name of Office or Physician: _____

Phone Number: ( ) _____ Fax Number: _____

Address: _____ Suite: _____

City: _____ State: _____ Zip Code: _____

I understand that this consent is revocable upon written notice where the original authorization is retained, except to the extent that action has already been taken on this authorization, and that the office has been taken in reliance on this authorization, and that consent shall remain for one year unless otherwise specified in order to effect the purpose for which it is given. Mental health, alcohol and/or drug abuse, HIV and/or AIDS, sexually transmitted diseases and other similar conditions are confidentially protected by Federal-State Law which prohibits disclosure without a specific written authorization of the undersigned or as otherwise permitted by such regulations. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Parent/Legal Guardian Name (Print): _____ Date: _____

Parent/Legal Guardian Signature: _____