Northwest Broward Pediatrics

Leon & Kronberg Pediatric Center

Request to release protected health information to Leon & Kronberg Pediatric Center

To: _____
Previous health care provider

Address: _____

Phone: _____

Fax: _____

I hereby authorize you to release to:

Leon & Kronberg Pediatric Center
5640 W Atlantic Blvd, Margate FL, 33063
Phone: (954)974-4414 Fax: (954) 975-7239

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Phone Number: _____

Please include immunizations, and significant issues for the duration of visits to your office.

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges including the cost of supplies, labor, and postage related to the production of my information. I understand that the charge for the paper copy is: $1.00 per page for the first 25 pages, then $.25 for each page thereafter.

_____ _____
Signature of Parent or Legal Guardian Date

_____
Print Name