Horizon West Pediatrics

PATIENT NAME: _____ Date of Birth: _____

I hereby authorize: _____

To release my confidential health information, as described below, to the staff at Horizon West Pediatrics

5730 Hamlin Groves Trail Ste 164 Winter Garden Fl, 34787

Phone Number: 407-347-7052 Fax Number: 321-282-6944

My authorization is for the use and disclosure of the following records:

_____Discharge Summary _____Physician Orders

_____History and Physical _____Operative Report

_____Laboratory Reports _____Immunization Record

_____X-ray Reports _____Progress Notes

_____EKG/Cardiovascular _____Entire Record

This _____day of_____ 20____

(Date) (Month)

_____

(Signature of Patient or Legal Guardian)