AUTHORIZATION TO TRANSFER MEDICAL RECORDS

I hereby authorize_____, M.D., to release all medical

records from my child _____ (DOB: _____) to:

Dr. Milagros G. Huerta
2999 NE 191st St. Suite 300
Aventura, FL 33180
Phone: (305) 935-2441
Fax: (305) 933-4438

Specifically we are requesting that you please send:
- all clinic visit notes
- copies of laboratory tests
- reports of radiology exams
- growth charts
- all heights and the dates when they were measured

Any and all information may be released except as specifically provided below:

_____
_____

I understand and agree to pay a reasonable charge to cover the cost the transfer. I understand the costs will be computed based on the copying fee, actual costs for the reproduction of oversized documents or documents requiring special processing, and reasonable clerical costs for locating and making the records available.

This authorization is effective now and will remain in effect until [date:]
_____

I understand that I may receive a copy of this authorization.

Signed:_____ Date: _____

__ Parent or _____ guardian of minor patient