***LAKE WORTH PEDIATRICS***
***3112 SOUTH CONGRESS AVENUE STE A***
***PALM SPRINGS, FL 33461***
***Ph: 561-964-0110***
***Fax: 561-964-0401***

# *MEDICAL RECORDS RELEASE FORM*

***PATIENT'S NAME*** _____ **D.O.B** _____

**I** _____, **authorize** _____

_____ **to release my son's/daughter's**

**medical records (including HIV information) to Dr. N. Shankaraiah at Lake Worth Pediatrics.**

**Date:** _____

**Parent:** _____

**Guardian:** _____