Authorization for Medical Records Request/Release

Patient's Name DOB:

_____ _____

You are hereby authorized to release/ request any medical notes, reports, labs, operative reports and films to/from Dr. Juan Gabriel Martinez and Periscope Pediatrics LLC.

We specifically request:

_____

_____

I hereby release Dr. Juan Gabriel Martinez, Periscope Pediatrics LLC, and its staff from liability and all claims of nature whatsoever, pertaining to disclosure of this information.

If I have requested these records for my own personal use, I am responsible for the safe keeping of these records. Dr. Juan Gabriel Martinez, Periscope Pediatrics, and its staff is not responsible if these records were to get damaged or lost once given to me.

Personal Representative

_____ _____

Parent/ Legal Guardian Signature Date