



THE PEDIATRIC SPECIALISTS MEDICAL GROUP P.A.

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MEDICAL RELEASE AUTHORIZATION FORM

I hereby authorize and request you to release any and all medical records and other pertinent patient information which may include but is not limited to complete history & physical, lab, and x-ray reports, immunizations, alcohol or drug abuse, HIV, mental health, or communicable disease information or any treatment or examination rendered.

Records Requested from:

Release Records to:

Name: _____

The Pediatric Specialists Medical Group

Address: _____

2044 Trinity Oaks Blvd., Suite 235

Trinity, FL 34655

Phone #: _____

Phone #: 727-375-5437

Fax #: _____

Fax #: 727-375-0502

Medical Records Requested: _____

You may refuse to sign this consent. This consent may be revoked at any time upon written notice, except to the extent that any person or organization has already taken action in release thereon. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. This form must be received within 90 days of signing and it is valid for 90 days after receipt.

Patient Name: _____ **DOB:** _____

Patient Address: _____

Patient Phone #: _____

Signature: _____

Print Name: _____ **Relationship to Patient:** _____

Witness: _____ **Date:** _____