SARASOTA CHILDREN'S CLINIC
Carola Fleener, MD
3920 Bee Ridge Rd
Bldg. A Ste C
Sarasota, Fl 34233
(941) 923-3667
(941) 924-3246 fax

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby request and authorize Sarasota Children's Clinic to:

Obtain from______________________________ Send to______________________________

______________________________ ______________________________

______________________________ ______________________________

The following medical information for the purpose of:

( ) Changing primary care ( ) Insurance ( ) Moving

( ) Specialty care ( ) Legal ( ) Personal______________________________

__All medical information and reports

__Diagnostic reports from_________to_________(dates)

__Lab results from________to________(dates)

__Immunizations

For the medical record of: **(please print)**

Patient (s) Name **Date of Birth**

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This authorization is specific for the above one time request. I understand I may withdraw my consent at any time.

______________________________ ______________

Signature of patient or legal representative/ Relationship Date

______________________________ ______________

Address of patient or legal representative Telephone #

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