

# Nadal Pediatrics

621 Victoria Street  
Brandon, Florida 33510  
Phone (813)655-0292  
Fax (813)655-4302

376 East Bloomingdale Avenue  
Brandon, Florida 33511  
Phone (813)681-7101  
Fax (813)571-7158

I, \_\_\_\_\_ as parent/legal guardian, of:  
(Parent/Guardian Name)

\_\_\_\_\_  
(Patient Name)

\_\_\_\_\_  
(Date of Birth)

\_\_\_\_\_  
(Patient Name)

\_\_\_\_\_  
(Date of Birth)

\_\_\_\_\_  
(Patient Name)

\_\_\_\_\_  
(Date of Birth)

Authorize: \_\_\_\_\_  
(Name of Medical Facility)

\_\_\_\_\_  
(Address of Facility)

\_\_\_\_\_  
(City, State, Zip)

\_\_\_\_\_  
(Phone)

\_\_\_\_\_  
(Fax)

To release medical records of the above named patient(s) in the form of immunization records, progress notes, psychiatric information, lab tests, and radiology reports to:

**Nadal Pediatrics  
621 Victoria Street  
Brandon, Florida 33510**

\_\_\_\_\_  
(Parent/Guardian Signature and Relationship to Patient)

\_\_\_\_\_  
(Date)

If you have provided us with your permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.