

**Pediatric Partners of Zephyrhills, P.A.**

Caring For Your Child From Birth To 18



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**OUTGOING  
REQUEST FOR RELEASE OF MEDICAL INFORMATION**

I hereby request you to release to me any information including diagnosis and records of any treatment or examination rendered to my child during the period

From \_\_\_\_\_ To \_\_\_\_\_

CHILD'S NAME \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

SEX \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

DATE \_\_\_\_\_

I understand that I am responsible for payment of a Medical Records fee at the time I pick up my records. The fee for my records is \_\_\_\_\_.

SIGNED \_\_\_\_\_

WITNESS \_\_\_\_\_

REASON FOR REQUEST \_\_\_\_\_

PLEASE MAIL MY RECORDS TO ME AT:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_