Avilio E. Munoz MD

HOLISTIC PEDIATRICS GROUP LLC

• Healthier Children through Integrative Healthcare •

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO: MEDICAL RECORDS DEPARTMENT

TELEPHONE: _________________________ FAX: _________________________

PATIENT NAME: ____

DATE OF BIRTH: ____________________________

I Hereby request that my Medical Record be Released to:

AVILIO E. MUÑOZ, MD
2906 W TAMPA BAY BLVD
TAMPA, FL 33607
FAX: 813.876.0336 PHONE: 813.879.1985

SPECIFIC DESCRIPTION OF INFORMATION REQUESTED

____SHOT RECORDS

____COMPLETE MEDICAL RECORDS

____LAB RESULTS

____OTHER REPORTS

SIGNATURE: ____ **DATE:** _________________

If the above signature is not the patient's, please print name and relationship to patient.

NAME OF RESPONSIBLE PARTY: ____

RELATIONSHIP: ____

Our HIPPA notice of Private Practices revised January 1, 2008 provides information about our use of a patient's protected health information (PHI).