



Pediatric Care Center

**4504 Diamond Ruby, Suite 3
Christiansted, St. Croix
U.S. Virgin Islands 00820
Telephone: 340-719-0681
Facsimile: 877-466-2165**

AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS

There is a fee of \$20.00 for medical records, that will be placed on a USB flash drive. Records will be ready in 7 business days.

Name- Last, MI		DOB:
Mailing Address:		Contact#:
City	State	Zip Code:

RECORDS RELEASE TO:

- Dr. Anthony Ricketts
- Dr. Trevena Moore
- Dr. Olajide Olawepo

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Records Release From: (Please check one)

- Hospital
- Clinical Lab
- Imaging Center
- STX MRI
- Other

(A photocopy, fax or electronic copy of this authorization shall be considered as effective and valid as the original)

Signature of the Patient: _____ **Date:** _____

If not signed by patient/guardian, please indicate relationship

Parent or guardian of minor patient

Guardian or conservator of an incompetent patient

Name of Parent\Guardian _____ *legal relationship* _____

Witness: _____ *Date:* _____

“With you every little step of the way”