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 7-10 business days.

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

By signing this form, I authorize you to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information, to the physician/person/facility/entity listed below.

RECORDS RELEASE TO/FROM:

- ☐ Dr. Anthony Ricketts
- ☐ Dr. Trevena Moore
- ☐ Dr. Olajide Olawepo
- ☐ Dr. Stacy Nichols-Byll

RECORDS RELEASE FROM/TO:

Facility Name _____

Fax/Email_____

The purpose/reason for this release of information is as follows:

_____

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

_____
Printed Name of Parent/Legal Guardian

_____ _____
Signature of Parent/Guardian **Date**

"With you every little step of the way"