Central Florida Pediatrics

Brenda Lewis, MD   Kacie Lutz, MD   Denise Drago, MD   Michelle Williams, MD
Dawn Diomede, ARNP   Kristin Affolter, ARNP

CONSENT FOR RELEASE OF CONFIDENTIAL RECORDS

Person completing form: ___________________________   ***Relationship:*** _____________

Information Requested From:
Central Florida Pediatrics
2881 Wellness Avenue
Orange City, FL 32763
Phone: (386) 917-0450
Fax: (386) 917-0457

Please forward copies of medical records to:
Name: ____
Address: ______________________________________
____
Phone: ____________________

If records going to parent/guardian: ☐ ***Pick-up*** ☐ ***Mail***

Patient's Name:	
Date of Birth:	
SSN:	

Patient's Name:	
Date of Birth:	
SSN:	

Purpose/Need for Information
Changing Physicians due to: ☐ Moving ☐ Insurance ☐ Dissatisfied with care ☐ Over 18
or
☐ Specialist ☐ Information for Insurance Purposes ☐ Other

Specific Documentation Required:
☐ Complete medical records
☐ Laboratory reports (*specify dates below*)
☐ Medical records in your possession from other sources
****PLEASE NOTE- there is a $1 per page fee that must be paid before the records will be released if you wish us to copy medical records from another source***
☐ Mental health records (such as notes with diagnosis of ADHD, behavioral disturbances, etc)
☐ Other: ____

This information, including diagnosis and records of any evaluation, examination and/or treatment rendered to the above named ***during the period:*** ___________ ***to*** ___________

Signature: _______________________________________ ***Date:*** _______________

Relationship: ___________________ ***Contact Phone Number:*** ________________

******If parent or guardian is mailing or faxing this form to the office, you must also provide a copy of your picture ID. We cannot release medical records without verifying the signature on the release.***

Witness: _______________________________________ Date: ______________

This request is authorized to include any Federal and/or State protected information under Florida Statues 394.459(9) Psychiatric Information. 397.053/396.112 Drug and/or Alcohol Abuse Information. 381.609 HIV and AIDS related conditions and/or 397.501(3) records of a minor client.

I understand that this authorization will expire 90 days from the date of signature or when acted upon, whichever event occurs first. I hereby release to the forwarding addressee, its employees and appointed representatives from any and all liability that may arise from the release of information as I have directed. I understand that if a patient has not been seen in our office during the past three years, there will be a $16.00 fee assessed for the retrieval of these records from our off-site records retention facility.

This authorization for the release of the above-indicated documents may be revoked at any time, upon notification of the patient or representative as signed above. Revocation has no effect on prior action taken under direction of the signed dated consent for release.