Central Florida Pediatrics

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AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS

Patient name: _____ Date of birth: _____
Patient name: _____ Date of birth: _____
Patient name: _____ Date of birth: _____
Current phone number: _____

RELEASE MEDICAL RECORDS FROM:

Name: _____
Address: _____

_____

Ph: _____ Fax: _____

RELEASE MEDICAL RECORDS TO:

Name: _____
Address: _____

_____

Ph: _____ Fax: _____

Medical records requested from dates: _____ to _____

Purpose/Need for Information

☐ Changing physicians ☐ Moving ☐ Specialist ☐ Insurance information
☐ At the request of the parent/guardian ☐ Other: _____

Specific Documentation Required:

☐ All medical records ☐ Specialist notes
☐ Immunizations/vaccines ☐ Laboratory reports
☐ Other: _____

I authorize the release of medical records ***with the exception*** of the following (please check all that apply)

☐ Mental health ☐ HIV/AIDS ☐ Drug/alcohol use ☐ Genetic testing

Signature: _____ **Date:** _____

Print name: _____ **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.***

For office use only 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 one year from the date of signature and/or may be revoked earlier by my request in writing. Revocation has no effect on prior action taken under direction of the signed dated consent for release. If I refuse to sign, my treatment, payment, enrollment or eligibility for benefits will not be affected. All records obtained will be used solely for professional purposes. PHI obtained may be subject to re-disclosure by the recipient and may no longer be protected by the Privacy Rule. I understand I have the right to inspect or copy the information to be used/disclosed as permitted by federal law. I understand that a copy of this relase is as valid as the original and I am entitled to a copy after I sign it. I hereby release Central Florida Pediatrics, its employees, staff, & representatives from all liability relating to or arising out of this release of information.