Central Florida Pediatrics

2881 Wellness Ave, Orange City, FL 32763 ~ Ph: 386-917-0450, Fax: 386-917-0457
735 Primera Blvd #135, Lake Mary, FL 32746 ~ Ph: 407-321-0085, Fax: 407-328-7658

AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS

Patient name: ______________________ Date of birth: ______________________
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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 ☐ Other: ______________________
☐ Immunizations/vaccines ☐ Laboratory reports

There will not be any charge for medical records that are sent to a PCP or specialist.
There will be a monetary charge for medical records that will be sent to the patient, parent or guardian.
I understand the charge for a paper copy is $1 per page for the first 25 pages, then $0.25 for each page thereafter.
I understand the charge for an electronic copy (flash drive) is $20.
Costs for reproducing medical records are in accordance with FL Statute 395.3025, Rule 64B8-10.003 of the FL Administrative Code

☐ **Paper** ☐ **Electronic/flash drive** ☐ **Email (FREE)** **Email address:** ______________________

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.