MEDICAL RECORDS RELEASE FORM

PEDIATRIC CARE GROUP, P.A.

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Orlando, FL 32822
407-275-2676 Phone
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Patient Name: _____

I, _____ Hereby Authorize Pediatric Care Group, P.A.
To □ Release To □ Obtain From □ Self Pay
Name: _____

Address: _____

City: _____

Phone: (_____)_____-_____ Fax: (_____)_____-_____

** PLEASE RELEASE MY MEDICAL RECORDS**
Initial by the item you want to have released

State Period of Time: From: _____/_____/_____ To: _____/_____/_____

____ 1. All Medical Records (Includes #2-8)

____2. Immunization Records

____3. Consultations

____4. Surgical Reports

____ 5. Laboratory Results

____ 6. X-Ray Reports

____7, ER/Urgent Care Records ALL

____ 8. Newborn/Birth Records
(Include Screen/Test Results)

This information is being disclosed for the following purpose:

____ Personal Copy (charges apply)
____ Continuity of care
____ Moving out of state

Medically Sensitive:

____ HIV/AIDS information
____ Mental Health Information
____ Substance Abuse Information
____ Sexually Transmitted Disease
____ Pregnancy Information (If under 18 years)

I recognize that the health information disclosed may contain information that is privileged and protected by law & I specifically consent to the disclosure of such information. I understand that I have the right to inspect or copy the information to be used/disclosed as permitted by federal law. All records obtained will be used solely for professional purposes, and will remain confidential. I understand that this consent is revocable by me, in writing, at any time except when action has been taken in reliance upon it**.** If I refuse to sign this authorization, my treatment, payment health plan enrollment, or eligibility for benefits will not be affected. **I also understand that this consent will expire ninety (90) days after date of signature or automatically when the records requested on this form have been sent.**

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by law. Any further re-disclosure is strictly prohibited.

PATIENT Name: _____Date of birth:____/____/_____

Parent/Guardian: _____ Date: ____/____/_____
(PRINT)

Parent Guardian: _____ Witness: _____
(SIGNATURE)