PEDIATRIC ASSOCIATES
FAMILY OF COMPANIES

REQUEST TO RELEASE PROTECTED HEALTH INFORMATION
PLEASE COMPLETE ONE FORM PER CHILD

Patient Name: _____ Date of Birth:_____

Patient Address: _____ Account /Chart: _____
Street Address

_____ Phone # _____
City, State, Zip

For Record Release or Copies: By signing this authorization, I authorize the party listed below to use and/or disclose certain protected health information (PHI) about me / my child. I also understand that I may revoke this authorization at any time, in writing, to the address listed below provided the information has not been released.

I authorize: **to release to**

Provider's Name

_____
Street Address

_____
City, State, ZIP

_____
Phone#

New Provider, Specialist, or Person Receiving Copy

_____
Street Address

_____
City, State, ZIP

_____
Phone#

For Patient or Legal Guardian Copy Requests: ( ) Paper ( ) Email ( ) Fax
I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies, electronic devices, labor, and postage related to the production of my information. I understand that the charge for paper copy is: **$1.00 each page for the first 25 pages, then $.25 for each page thereafter. Digital Radiology Image copies onto CD are $10.00.**
Costs for reproducing medical records are in accordance with the FL Administrative Register Rule 64B8-10.003 and F.S. 164.524 ©4.

***Information to be Released/Requested*:** ( ) All pertinent medical records ( ) Immunizations
( ) Labs -dates: _____ ( ) X-ray images- dates: _____ ( ) Other: _____

***Information to be Excluded / Not Released*:** ( ) Mental Health Records ( ) Drug/Alcohol Treatment
( ) HIV Testing ( ) Sexual Assault/Victimization Records ( ) Other: _____

Reason for Record Release*:** ( ) Personal copy (see above – charges apply***) ( ) Over age 21 ( ) Continuity of Care
( ) Change of Insurance ( ) Referral to Specialist ( ) Moving out of state ( ) Leaving Practice
( ) Unhappy due to wait time ( ) Unhappy due to Customer Service
( ) Unhappy with Provider or Practice (Please state why) _____

***Inspection requests are valid on the date of signature only / Release or Copy requests expire 30 days from signature date**
***Please allow up to 30 days for processing**

_____ _____ _____
Signature of Patient or Legal Guardian Printed Name of Patient or Legal Guardian Date

Prohibition of Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by law. Any further disclosure is strictly prohibited unless the patient/legal guardian provides specific written consent for subsequent disclosure of this information. These records may be protected by federal regulation (42 CFR, Part 2).