

First Choice Pediatrics©

Alafaya-Orlando-Sanford

Authorization for Release of Confidential Medical Records

1 Name of Healthcare Provider/Physician/Facility or persons authorized to release patient information:

Street Address: Phone:

City / State / Zip: Fax:

2 By signing this, I authorize the above to disclose protected health information about the person named below.
Patient Name (print): _____ Date of Birth: _____

3 This information is to be released to:

Name: _____
Address: _____ Phone and
Fax: _____

4 Please check one: **All medical records**, meaning every page in my record, including but not limited to: office notes, face sheets, history and physical, consultation notes, inpatient, outpatient and emergency room treatment, all clinical charts, reports, order sheets, progress notes, nurse's notes, social worker records, clinic records, treatment plans, admission records, discharge summaries, requests for and reports of consultations, documents, correspondence, test results, statements, questionnaires/histories, correspondence, photographs, videotapes, telephone messages, and records received by other medical providers. All physical, occupational and rehab requests, consultations and progress notes. All disability, Medicaid or Medicare records including claim forms and record of denial of benefits. All employment, personnel or wage records. All autopsy, laboratory, histology, cytology, pathology, immunohistochemistry records and specimens; radiology records and films including CT scan, MRI, MRA, EMG, bone scan, myelogram; nerve conduction study, echocardiogram and cardiac catheterization results, videos/CDs/films/reels and reports. All pharmacy/prescription records including NDC numbers and drug information handouts/monographs.
Other (please specify): _____ (p p y)

5 By signing below I acknowledge the following statements: a. b. c. d. e. f. g. h. I understand that I may revoke this Authorization at any time by sending a written request to the privacy officers at any of the facilities holding this authorization. Such revocation will not have any effect on any action taken by an facility before the revocation. This authorization will expire six (6) months from the date of signature, or when revoked or on the following date . I understand that this information may include information relating to: 1) Acquired Immune Deficiency Syndrome (AIDS) or HumanImmunodeficiency Virus (HIV) Infection, 2) Mental or behavioral health or psychiatric care, 3) Treatment of drug or alcohol abuse. I understand that the information disclosed pursuant to this Authorization may be subject to re-disclosure by the party who receives itbecause it may no longer be protected by the federal privacy laws. I understand that records in electronic form can be distributed on a wide scale with relative ease and losses or unintended releases of the requested information may occur under circumstances beyond the control of the facility records are released to, its release of information vendor or the person making the request. By requesting records in this format, the Requestor is knowingly and voluntarily assuming this risk and all consequences, losses and damages that might result. If an facility has requested this Authorization, I understand that the requesting facility will give me a copy of this Authorization form after I sign it upon request. I understand that any facility may not condition treatment, payment, enrollment or eligibility of benefits on the completion of this Authorization. This information will be used / disclosed for the following purpose(s):

6 Signature of Patient or Legally Authroized Representative: Sign: _____
Date: _____

Name and Relatiionshp of Legally Authroized Representative to Patient: Name(please print): _____ Relationship: _____

1651 N. SEMORAN BLVD • ORLANDO, FL 32807 • P:407-249-1234 • F: 407-249-1755