FIRST CHOICE PEDIATRICS
Semoran/Alafaya/Metrowest/Sanford/Kissimmee/Oviedo/Winter Springs

1651 N. Semoran Blvd. Orlando, FL 32807
Phone#: 407-249-1234 Fax#: 407-249-1755

AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Current Phone: _____

Current Address: _____

RELEASE MEDICAL RECORDS FROM:

Name or Facility: _____

Address: _____

Phone: _____ Fax: _____

DISCLOSE MEDICAL RECORDS TO:

Name or Facility: _____

Address: _____

Phone: _____ Fax: _____

I AM REQUESTING MEDICAL RECORDS FROM DATES: **FROM:** _____ **TO:** _____

Please send my requested information by:
☐**Fax**: _____ ☐**Mail**: _____ ☐**Email**: _____
Note: It is preferred to send records via fax.

I authorize the following types of information to be released:

☐ All medical records	☐ Operative Notes
☐ Labs/Pathology/Imaging	☐ Growth Charts
☐ Immunizations/Vaccines	☐ Medications
☐ History/Physicals	☐ Photos
☐ Specialist Consultations	☐ Billing Statements
☐ Hospital Records	☐ Other:

Your initials are required to release the following:
_____ Psychiatric/Psychological Evaluations and Notes
_____ Drug/Alcohol Results
_____ HIV/STD Report
*If Requesting Adolescent Encounters Minor Must Sign:
_____

Purpose of Disclosure: (Please Specify):

☐ Transfer of Care	☐ Personal Use
☐ Continuity of Treatment	☐ Other: _____

Expiration Date: _____
*If left blank, this authorization will expire one year from the date signed.

I recognize that the health information disclosed may contain information that is privileged and protected by law and I specifically consent to the disclosure of such information. I understand 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 and may not be disclosed to third parties. This authorization may be revoked by me in writing to First Choice Pediatrics at any time. A written cancellation in the future will have no effect on any records that may have been released prior to the receipt of the written cancellation. Information released may be subject to re-disclosure by the recipient. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected. I understand that a copy of this release is as valid as the original and I may also receive a copy of this form after I sign it. In consideration of this consent, I hereby release the above parties from any and all liability arising there from.

Signature of **Patient/Parent/Legal Guardian**: _____

Print Name of **Patient/Parent/Legal Guardian**: _____

Date: _____

Relationship to Patient: _____

Notice: There may be a cost for producing medical records in accordance with State and Federal Law