FIRST CHOICE
PEDIATRICS
part of the PEDIATRIC ASSOCIATES family

# AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

*Complete One Form Per Patient and for use in Florida only*

**Patient Information:**

Name _____ Date of Birth _____

Street Address _____ Social Security _____

City, State, Zip Code _____ Phone Number _____

**Release Medical Records From:**

Name _____

Phone Number _____

Street Address _____

Fax Number _____

**Release Medical Record To:**

Name _____

Phone Number _____

Street Address _____

Fax Number _____

**Medical Records to be Released:**

__DISCHARGE SUMMARY ___IMAGING ___PROGRESS NOTES

__ECG ___LABORATORY REPORTS ___RADIOLOGY REPORTS

__HISTORY & PHYSICAL ___PATHOLOGY REPORTS ___OTHER _____

**Dates of Service**: _____/_____/_____ to _____/_____/_____

**Purpose of Release of Medical Records:** (please check below)

___TRANSFER OF CARE TO A NEW PROVIDER. YOU MUST CONTACT YOUR INSURANCE TO CHANGE PCP (INITIALS): _____

___REFERRAL TO SPECIALIST ____PERSONAL __DISABILITY DETERMINATION ___INSURANCE ____LEGAL INVESTIGATION

___Other (please specify) _____

___ I DO ___I DO NOT authorize the release of information related to AIDS (acquired immunodeficiency syndrome) or HIV (human immunodeficiency virus) infection, psychiatric care and/or psychological assessment, and treatment for alcohol and/or drug abuse (INITIALS): _____

I acknowledge that, by signing this authorization, I am either a legal representative or an authorized person requesting the release of medical records for the patient mentioned in this form. I hereby authorize disclosure of the health information for the above-named patient. This authorization is valid 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is authorized to be furnished may not condition its treatment of me on whether I sign the authorization.

_____ _____ _____

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

**help@recordquest.com (888)300-7410 www.recordquest.com**

First Choice Pediatrics has partnered with RecordQuest to collect payments, complete requests for records, and provide status updates. You may receive communications from RecordQuest during the request process. Any information you share is used strictly to fulfill your request.