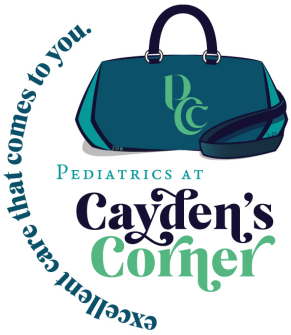

Release of Medical Records FROM Pediatrics at Cayden's Corner

Patient Information

Patient Name:_____ DOB: __/__/____

Patient Name:_____ DOB: __/__/____

Patient Name:_____ DOB: __/__/____

Patient Name:_____ DOB: __/__/____

If leaving our practice, please indicate reason(s):

☐ *Moving out of Tampa Bay area*
☐ *Insurance*
☐ *Age of patient*
☐ *New pediatrician*
☐ *Other (please specify):*

_____

Release Records TO *(doctor, facility, or individual)*: _____

Address:_____

City / State / Zip:_____ Phone: (____) _____ - _____ Fax: (___) _____ - _____

Please identify the information to use, release, obtain or disclose:

☐ Please release entire record

OR

☐ Please release ***only*** the following information *(check appropriate boxes and include other information where indicated)*:

☐ Immunization Records
☐ Medication List
☐ History of Illness
☐ Allergy List

☐ Lab Results *(please list dates or types of lab tests you would like disclosed)*:
_____
_____

☐ Most Recent History
☐ Other *(please specify)*:
_____
_____

Authorization *(initial each item below)*

____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

This authorization will expire on *(insert date or event)*: _____

If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

The identified information will be used for the following purpose:

☐ My personal records ☐ Sharing with other health care providers as needed ☐ Other: _____

_____ _____ _____

Name (print) **Signature** **Date**

Relationship to Patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Other (please specify): _____

_____ _____ _____

Witness Name (print) **Witness Signature** **Date**