Patient's Request and Authorization for Release of Medical Information

I hereby authorize:

Dr._____
Address:_____
Phone No.#_____

to release medical information to:

Pediatric Professional Associates
7001 SW 87 Avenue
Miami, Florida 33173
Tel#: 305-271-8222
Fax#: 305-274-6316

Patient Name: _____**Date of Birth**: _____

This request applies to the following information to be provided one time, as soon as possible:

- ☐ The following records or types of health information: immunization record with problem list and growth chart.
- ☐ All health information pertaining to any medical history, physical condition, and treatment received, except items listed below unless circled.
- ☐ Confidential medical records including psychological or psychiatric records, records of drug testing, drug or alcohol treatment, records of HIV/AIDS testing, diagnosis or treatment, records of sexually transmitted diseases testing and treatment.

_____

Reason for requesting copy medical records:

- ☐ Relocating to another area.
- ☐ Change of Insurance Plan to:_____
- ☐ Other:_____

If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may be re-disclosed and may no longer be protected.

Signature: _____**Date:** _____

(Patient/Representative/Spouse/Parent/Legal Guardian/Financially Responsible Party)

- ☐ *If signed by someone other than the patient, state your legal relationship to the patient:

_____

Witness: _____

*A spouse or financially responsible party may only authorize release of medical information for use in processing an application for the patient, as a spouse or dependent, for a health insurance plan or policy, a nonprofit hospital plan, a health care service plan or an employee benefit plan.