



Caring Pediatrics

4439 Rowan Rd

New Port Richey, FL 34653

Phone (727)853-CARE Fax (727) 853-2277

http://www.caringpediatrics.com

Authorization to Release Medical Records

Name _____ Birth date _____ Phone () _____

Address _____ City, State, Zip code _____

Please obtain information from:

Name of Provider/Clinic/Organization

Street Address

City, State, Zip code

Phone/Fax numbers

Please send information to:

Caring Pediatrics

Name of Provider/Clinic/Organization

4439 Rowan Rd

Street Address

New Port Richey, FL 34653

City, State, Zip code

(727) 853-2273 (727) 853-2277 (fax)

Phone/Fax numbers

I authorize the following information to be disclosed: (please mark all that apply)

- Complete Health Records
- Progress Notes
- Growth Charts
- Problem list, Growth chart, Medication history, last well visit, latest consult notes, and immunizations
- All records for the following dates: _____
- Immunization Records
- Medication History
- Well Visits/Physicals
- Other _____
- Consultations
- Medication History

I understand that information in my record may include information relating to sexual history, sexually transmitted diseases, HIV or AIDS, psychiatric or mental health services, as well as drug and alcohol use.

- I do not Authorize the release of my medical records.

Expiration of this Authorization:

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke my authorization, I must do so, in writing, to Caring Pediatrics. I understand that the revocation will not apply to my insurance company when the law provides my insurer the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:

If I fail to specify an expiration date, event or condition, this authorization will expire in ninety days. I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization, and regardless, I will receive treatment. I understand that I may copy and read the information disclosed. I understand that any disclosure of information carries the possibility for unauthorized re disclosure and the information may not be protected by federal confidentiality rules.

Signature of Patient or Guardian

Signature of Witness

Name of Patient or Guardian Relationship

Name of Witness

Date

Date

- Pick up Records
- Mail Records
- Fax Records