7645 Cita Ln, Suite 102
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, PA
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:

Immunization Records	Progress Notes (last two)	Medication History	Consultations
Growth Charts	Well Visits/Physicals (last two)	Problem List	Labs for past yr.
Past payment hx			

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.

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