AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Failure to fill out this form, so past medical records can be obtained, may result in your child being discharged from our practice

Patient Name: _____ Date of Birth: ____/____/____

INFORMATION DISCLOSED TO:

Person/Facility: Medical Records Department|Angel Kids Pediatrics Phone: (904) 224-5437

Address: 4160 Boulevard Center Rd. Jacksonville, FL 32207 Fax: (904) 862-6159

INFORMATION REQUESTED FROM:

Person/Facility: _____ Phone: _____

Address: _____ Fax: _____

For the Purpose of:

☐ Continuity of Care ☐ Personal Use ☐ Other:_____

Information to be disclosed (*via fax, mail, or other HIPAA Compliant method***):**

☐ General Medical Records ☐ Medical History ☐ Physical Results ☐ Progress Notes

☐ Diagnostic Test Results ☐ Immunization Records ☐ Consultant Notes ☐ Other:_____

Please initial the statement below

____ These records may include information relating to: Sexually Transmitted Diseases, HIV/AIDS, Tuberculosis, drug or alcohol abuse, pregnancy, mental health, child abuse, early intervention, and / or WIC eligibility.

The authorization will expire on ____/____/____. I understand that if I fail to specify an expiration date, this authorization signature will expire (6) months from the date on which it was signed.

Parent/Guardian Signature: _____ Today's Dates: ____/____/____

Print Name: _____ Relationship to Patient: _____

*** NO DISC(S) - THANK YOU ***