Pediatric Specialist

4950 S. LeJeune Rd.
Suite F
Coral Gables, FL 33146
(305) 665-3523 (p)
(305) 665-2272 (f)

MEDICAL RECORD RELEASE AUTHORIZATION FORM

The following information is required by law before we can release the medical records of your child. (See:2016 Florida Statutes, Title XXXII, Chapter 456.057)

PATIENT NAME:_____ DATE OF BIRTH:_____

ADDRESS:_____

CITY / STATE / ZIP: _____ PHONE:_____

I, the undersigned, hereby:

☐ Authorize **PEDIATRIC SPECIALIST** to release my Protected Health Information to the following person(s)/organization(s):

Name_____

Address_____

City / State / Zip _____

Phone:_____ Fax:_____

☐ Authorize release of my Protected Health Information to: **PEDIATRIC SPECIALIST, 4950 S. LEJEUNE ROAD, SUITE F, CORAL GABLES, FL 33146** from

_____ Fax:_____
(Primary Care Physician and/or Healthcare Provider)

REASON FOR REQUEST (PLEASE CHECK ONE):

☐ Transfer to Another Provider ☐ Legal/Custody Purposes ☐ Appointment with Specialist

☐ Personal Use ☐ Insurance Purposes ☐ Other_____

INFORMATION TO BE RELEASED: *(Please Note: We do not copy information generated by other physicians / offices.)*

☐ Last Well Child Visit & Immunizations ☐ Immunization Record Only ☐ Laboratory Results_____

☐ Entire Record ☐ Other Specified Records_____

☐ Records generated by this office (e.g.: recent physical, shot/med record, growth chart, problem list, and routine labs) **including** HIV Test Results, Mental Health, Drugs, and Alcohol, and Psychiatric and Psychotherapy Treatment.

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COPY FEE:

1. There is NO Fee for records faxed to another Provider. Please allow time.

2. Request for paper copies by the patient/parent will be charged $1.00 per page, for the first 25 pages, and $0.25 per additional page thereafter, plus postage/shipping if mailed. Requests from other parties (ie: Attorney, Disability, Insurance Company, Personal Representative, etc) Fee is determined by file size, and range from $50.00 to $100.00. Charges are in compliance with the, Florida Administrative Code, Statute 64B8-10.003.

I authorize the release of copies of medical records and/or other information as noted above. If specifically indicated by me above I understand that this may include information concerning the following: psychiatric/psychotherapy records, mental health records, drug and alcohol treatment information, specific confidential HIV-related information, and/or any general physical condition information. I authorize this information be released by routine mail or pick-up. I understand that I may revoke this authorization at any time to the extent that the person who is to make the disclosure has already acted in reliance on this authorization. If not revoked earlier, this consent will remain in effect for thirty (30) days and will only be accepted if completed in its entirety.

_____ _____
Signature of Patient or Parent/Guardian (if patient is under 18) Date

_____ _____
Print Name of Patient or Parent/Guardian (if patient is under 18) Relationship to Patient