Palmetto Pediatrics

218 9th St Dr W
Palmetto, FL 34221
(941) 721-3900
Fax (941) 721-7403

Palmetto PEDIATRICS

Manasota Pediatrics 3425
University Pkwy # 103
Sarasota, FL 34243
(941) 355-1777
Fax (941) 355-7788

Authorization to Release Medical Records / Information

Patient / Child's Name: _____ DOB: ___/___/_____

Release Records for (please check one): Referral Specialist Transferring Care Personal Use

From (The Facility sending records to Palmetto / Manasota Pediatrics)

Name of Facility:_____ Phone #: (____) ____-_____ Fax: (____) ____-_____
Address: _____ City: _____ State: _____ Zip: _____

Name of Facility:_____ Phone #: (____) ____-_____ Fax: (____) ____-_____
Address: _____ City: _____ State: _____ Zip: _____

To (The Facility receiving records from Palmetto / Manasota Pediatrics)

Name of Facility:_____ Phone #: (____) ____-_____ Fax: (____) ____-_____
Address: _____ City: _____ State: _____ Zip: _____

Name of Facility:_____ Phone #: (____) ____-_____ Fax: (____) ____-_____
Address: _____ City: _____ State: _____ Zip: _____

Authorization *(initial each item below)*

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. _____

I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. _____

I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. _____

I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment. _____

This authorization will expire on (insert date or event): (insert expiration date) ____/____/_____.
If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

_____ _____ ___/___/_____
Name (print) Signature Date

Relationship to Patient: ◯Self ◯Parent ◯Legal Guardian ◯Other (please specify): _____

_____ _____
Witness Name (print) Witness Signature