ANGEL KIDS PEDIATRICS

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 requested from:

Person/Facility: _____ Phone: ____(_____)_____

Address: _____ Fax: ____(_____)_____

**** Please only fax a maximum of 25 pages. If more than 25 pages, please mail to our office. Thank you! ****

Information may be 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**

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 ☐ Consultation 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: _____ Todays Date: _____

Print Name: _____ Relationship to Patient: _____

* NO DISCS, Thank you! *