Personal Care Pediatrics, PA
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Margate, FL 33063
Phone: (954) 974-3006
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Authorization for Release of Confidential Information

Patient Name: ________________________________ DOB: __________ Phone #: ____________________

Address: ____

I authorize PCP to: ☐ **Release my medical records to:** ☐ **Obtain my medical records from:**

____

Address: ____

Check confidential information to be Released or Obtained:

- ☐ Problem list
- ☐ Laboratory results from (date) __________ to (date) __________
- ☐ X-ray and imagine report from (date) _______ to (date) _________
- ☐ Consultation reports from (doctor's name) ____
- ☐ Progress notes (date) ____________________ to (date) _____________
- ☐ Entire record
- ☐ Immunization record
- ☐ Most recent history and physical
- ☐ Other ____

The purpose of this information is for: ☐ Transfer ☐ Continuity of Care ☐ Attorney ☐ Insurance

☐ Other: ____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in 60 days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.

____ __________________

Signature of patient or legal representative Date

____ ____________________________

Relationship to patient, if not signed by patient Witness signature

Note: I understand that 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 that this information is protected by law under certain conditions. By signing this statement, I am authorizing the release of this information to the requesting party above.

Signature of patient or authorized representative ____