Medical Records Release

Premier Pediatrics
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Ocoee, FL 34761
407-290-2394
Fax 407-521-3640

Request for Access and Authorization for Use and/or Disclosure of Protected Health Information

Please allow a minimum of two business days to process your request.

I understand that the protected health information specified below may include mental health, substance abuse (e.g., drugs, alcohol) HIV/AIDS status information, diagnostic and treatment records.

I have read and understand the following statements:

1. I may revoke this authorization at any time by notifying Premier Pediatrics in writing.
2. I understand that my revocation does not affect any disclosure made prior to the revocation being received and processed.
3. I understand the information disclosed may be subject to redisclosure and no longer be protected by federal or state privacy laws.
4. I understand that I am signing this form voluntarily and I am signing this under my own free will. Premier Pediatrics will not condition my treatment, payment, enrollment in health plans or my eligibility for benefits by signing this form.
5. I understand that I will receive a signed copy of this form, if requested
6. I further agree to pay charges to provide the information requested per the Florida Statutes
7. I understand that unless otherwise revoked, this authorization will expire upon the following date, event or condition: ________________________________. If no expiration date, event or condition is noted this authorization will expire 1 year from the date signed.

_____I understand and agree to the provisions of this form on behalf of the individual patient indicated below. **I have signed my name individually as the parent of the patient** or as the legal guardian of the patient. If I am the legal guardian, I have attached a copy of the court order designating me as the guardian of the patient.

OR

_____I am the patient and I understand and agree to the provisions of this form/authorization

Patient's Legal Name: ____

Date of Birth: ________________________________

Patient/Parent/Legal Guardian Phone Number:____________________________________

I authorize Premier Pediatrics to: Disclose to: ___________________________________

Obtain from:____

Address: ____

City: ________________________________ State: _________ Zip: ___________________

Phone: ______________________________ **FAX**: ________________________________

The purpose of this request:

Personal Request_____________ Treatment (Continued Care)____________

Other:____

Please furnish the following information specified below for the following dates:_______________

Circle one:

shot record only, Complete chart, Other: ______________________________________

Parent/Guardian Signature: ____

Print Name:____

OR

Patient Signature: ____

Printed Patient Name:____

Date :_____________________________________

Per Florida Statute 456.057 and Department of Health Chapter 64B8-10.003 reasonable costs of reproducing copies of written or typed documents or reports shall not be more than the following: For the first 25 pages, the cost shall be $1.00 per page. For each page in excess of 25 pages, the cost shall be 25 cents per page. Revised 5-18-12