Request For Medical Records

Release to/Obtain from: Name_____

Address_____

City:_____ State:_____ Zip:_____

Telephone #:_____ Fax#:_____

I HEREBY AUTHORIZE AND REQUEST THAT THE MEDICAL RECORDS OF THE FOLLOWING CHILD/CHILDREN BE **RELEASED TO** OR **OBTAINED FROM: (CIRCLE ONE)**

Premier Pediatrics
10,000 West Colonial Drive, Suite 390
Ocoee, FL 34761
Tel. 407-290-2394
Fax 407-521-3640

_____**This request is for the complete medical record,** including (initial all that apply):

_____ Psychiatric/mental illness _____HIV testing _____ARC and/or AIDS

_____Drug and or/ alcohol abuse _____ Other:_____

OR

_____ **This request is for the following information only**:_____

_____

I understand that this consent is revocable upon written notice to our office, except to the extent that action has already been taken on this authorization. Alcohol, drug, HIV, ARC and/or AIDS information, if present in the record, will be disclosed only if authorized above.

This information is confidentially protected by federal law which prohibits further disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I further understand that I may select which information from the above list of confidential information will be released, by placing my initials in the area provided.

Child/Childrens's Name:_____ DOB_____

_____ DOB _____

_____ DOB _____

_____ DOB _____

_____ DOB _____

_____ _____
Parent/Guardian/Legal Representative Signature Date

Per Florida Statute 456.057 and Department of Health Chapter 64B8-10.003 reasonable costs of reprodueing 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.