Medical Records Release

Premier Pediatrics
10,000 West Colonial Drive, Suite 390
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