



# Florida Pediatric Associates

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

*Please complete all sections of this form and return to: Pediatric Eye Consultants of North Florida  
Fax: 904.425.9414*

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Medical Record #: \_\_\_\_\_

I hereby authorize Florida Pediatric Associates to release medical, psychological, psychiatric, developmental-alcohol and/or drug abuse, human immunodeficiency virus (HIV) testing and treatment, AIDS related information, and genetic information as it concerns the above referenced patient as follows:

For the dates of service from: \_\_\_\_\_ to: \_\_\_\_\_

### RELEASE TO:

\_\_\_\_\_  
ENTITY OR PERSON NAME

\_\_\_\_\_  
STREET ADDRESS

\_\_\_\_\_  
CITY, STATE, ZIP

\_\_\_\_\_  
TELEPHONE

\_\_\_\_\_  
FAX NUMBER

### WHAT TO RELEASE:

- ☐ All Medical Records/Information ☐ Abstract ☐ Billing records ☐ Outpatient Record ☐ Diagnostic Test/Results  
☐ History & Physical ☐ Discharge Summary ☐ Other: \_\_\_\_\_

### PURPOSE (i.e., my medical care, legal purposes, etc.):

\_\_\_\_\_  
**FORMAT:** I request that my medical information be provided as follows:

- ☐ On paper ☐ In an electronic format ☐ Discuss my medical information only ☐ Other: \_\_\_\_\_

If requesting an unencrypted format, by signing below I acknowledge that I understand the inherent risks involved with sending and receiving information in an unencrypted, unsecured, format (such as regular email or unencrypted disc). Such risks include misdirected messages, email intrusion, interception, or views by unauthorized parties.

### EXPIRATION:

This authorization will be valid for one year from the date signed, unless otherwise specified here: \_\_\_\_\_  
Expiration Date

This authorization is voluntary. Refusal to sign this authorization will not lead to an impact on my treatment, or refusal by my Florida Pediatric Associates provider to provide treatment services to me/my child. I understand that my provider may charge a reasonable fee, as allowed by law, for a copy of my/my child's health information. I may revoke this authorization by submitting my request in writing to the clinic or department where I submitted this authorization but understand that such revocation will not apply to actions already taken by my health care provider prior to my revocation. I also understand that once my/my child's medical information is disclosed based on this authorization, it may be further used or disclosed and will no longer be protected by state or federal privacy laws.



# Florida Pediatric Associates

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or representative)

\_\_\_\_\_  
(Relationship to patient if not patient) Telephone Number: \_\_\_\_\_

*For individuals/representatives acting on behalf of the patient, you must indicate your relationship to the patient above, and attach proof of your authority to act on the patient's behalf (other than natural parents).*