

TRANSFER INTO

**PENSACOLA PEDIATRICS, P.A.**



**PATIENT AUTHORIZATION FOR USE AND DISCLOSURE  
OF PROTECTED HEALTH INFORMATION and  
REQUEST FOR RELEASE OF MEDICAL RECORDS**

To: \_\_\_\_\_  
PHYSICIAN'S NAME

\_\_\_\_\_  
ADDRESS

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

**I HEREBY REQUEST THAT MY CHILD'S MEDICAL RECORDS BE RELEASED TO:**

**PENSACOLA PEDIATRICS, P.A.** (Circle Location)

4951 Grande Dr. Pensacola, FL 32504 (850) 473-0100 (850) 473-0500 Fax	9301 Beatrice Drive Pensacola, FL 32514 (850) 476-7555 (850) 466-3777 Fax	1368 Country Club Rd. Gulf Breeze, FL 32563 (850) 934-9876 (850) 916-0736 Fax	2120 E. Johnson Ave. #103 Pensacola, FL 32514 (850) 494-3965 (850) 494-3966 Fax
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\_\_\_\_\_  
PATIENT'S NAME Date of Birth

\_\_\_\_\_  
PATIENT'S NAME Date of Birth

I authorize you to use and/or disclose certain protected health information (PHI) about me to Pensacola Pediatrics, P.A.

- All Office Records
- Discharge Summary Only
- Newborn Records to include H&P, Hepatitis B Immunization Record, Obstetrical Nursing Assessment, Labs and D&C Summary if applicable.
- Other
- Immunization Record Only
- ER/Urgent Care Visit including Lab/Xray Results

This information will be used or disclosed for the following purpose:  
AT THE REQUEST OF THE INDIVIDUAL

This authorization will expire upon receipt of these records at Pensacola Pediatrics.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing expect to the extent the practice has acted in reliance upon this authorization. My written revocation must be submitted to the HIPAA privacy Officer at Pensacola Pediatrics, 4951 Grande Drive, Pensacola, FL 32504. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

\_\_\_ I DO \_\_\_ I DO NOT authorize the release of information, including, if applicable, specific laboratory test of HIV infection (Human Immunodeficiency Virus, the causative agent of AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, all medical records or other information regarding my treatment, hospitalization including psychological or psychiatric impairment, drug abuse and/or alcoholism or sickle cell anemia.

Phone: \_\_\_\_\_

Signed by: \_\_\_\_\_  
Signature Print Name Date