PENSACOLA PEDIATRICS, P.A.

Release of Medical Records TO BE RECEIVED BY Pensacola Pediatrics, P.A.

Please check the office at which the patient is established.

	LOCATION	ADDRESS	CITY	PHONE	FAX
☐	Cordova	4951 Grande Dr	Pensacola 32504	850-473-0100	850-473-0500
☐	Nine Mile	9301 Beatrice Dr.	Pensacola 32514	850-476-7555	850-466-3777
☐	Tiger Point	1368 Country Club Rd.	Pensacola 32563	850-934-9876	850-916-0736
☐	Scenic Hills	965 E. Nine Mile Rd.	Pensacola 32514	850-466-3776	850-497-6939
☐	Milton	5834 Berryhill Rd.	Milton 32570	850-623-5437	850-626-7803
☐	Pace	5755 Quintette Rd.	Pace 32571	850-995-8087	850-994-5292
☐	Navarre	8738 Ortega Park Dr.	Navarre 32566	850-934-5776	850-710-7140

Release Records FROM *(Physician, facility or individual):* _____

_____

Address Line 1: _____

Address Line 2: _____

City, State, Zip: _____ Phone: _____ Fax: _____

Email Address: _____

Patient Information

Patient Name: _____ Date of Birth: _____

Records to be Released:

☐ All Medical Records ☐ Immunizations Only ☐ Itemized Billing

☐ Other: _____

Dates of Service:

☐ Please provide a complete copy of all dates of service.

☐ Please provide a complete copy of records from: _____ through _____ .

Purpose for Disclosure:

☐Transfer of Care ☐ Continuity of Care

(Changing to a new physician/moved to a new area.) *(Sending to a specialist or secondary facility.)*

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 the 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 agents 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.

Signature: _____ Date: _____

Print Name: _____ Phone #: _____