PENSACOLA PEDIATRICS, P.A.

Release of Medical Records FROM Pensacola Pediatrics, P.A.

Please check the office at which the patient is established.

☐	Cordova	4951 Grande Dr.	Pensacola, FL 32504	Phone: 850-473-0100	Fax: 850-473-0500
☐	Nine Mile	9301 Beatrice Dr.	Pensacola, FL 32514	Phone: 850-476-7555	Fax: 850-466-3777
☐	Tiger Point	1368 Country Club Rd.	Gulf Breeze, FL 32563	Phone: 850-934-9876	Fax: 850-916-0736
☐	Scenic Hills	965 E. Nine Mile Rd.	Pensacola, FL 32514	Phone: 850-466-3776	Fax: 850-497-6939
☐	Milton	5934 Berryhill Rd.	Milton, FL 32570	Phone: 850-623-5437	Fax: 850-626-7803
☐	Pace	5755 Quintette Rd.	Pace, FL 32571	Phone: 850-995-8087	Fax: 850-994-5292
☐	Navarre	8738 Ortega Park Dr.	Navarre, FL 32566	Phone: 850-934-5776	Fax: 850-710-7140

Patient Information

Patient Name: _____ Date of Birth: _____

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

_____

Address Line 1: _____

Address Line 2: _____

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

Email Address: _____

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 *(Changing to a new physician/ moved to a new area.)*

☐ Continuity of Care *(Sending to a specialist or secondary facility.)*

☐ Personal Copy *(If leaving our practice please select Transfer of Care.)*

At the request of the individual

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 #: _____