# PENSACOLA PEDIATRICS, P.A.

## Release of Medical Records FROM 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 |

**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 #: _____