



AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

1. I hereby authorize St. Petersburg Pediatrics to disclose the following information from the health record of:

Patient Name: _____
Reason for record release: _____
Doctor's Address: _____

Telephone: _____ Fax: _____

Covering the period(s) of health care:

From (date) _____ to (date) _____

2. Information to be disclosed:

<input type="checkbox"/> Complete Health record	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> History & Physical	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Laboratory Test
<input type="checkbox"/> X-Ray Reports	<input type="checkbox"/> STD Information
<input type="checkbox"/> Other: _____	

I understand that this will be information relating to (check if applicable):

Acquired Immunodeficiency Syndrome (AIDS) Human Immunodeficiency virus (HIV) Information
 Behavioral Health Service/Psychiatric Care
 Treatment for Alcohol and/or Drug Abuse

3. This information is to be disclosed to:

Doctor's Address: _____

Telephone: _____ Fax: _____

Family Member: _____

Telephone: _____ Fax: _____

(I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire one year from date signed.)

4. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

(Parent or Legal Representative) Date: _____

(Signature of Witness) Date: _____