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:

_____ Complete Health record
_____ History & Physical
_____ Consultation Reports
_____ X-Ray Reports
_____ Discharge Summary
_____ Progress Notes
_____ Laboratory Test
_____ STD Information
_____ 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.)

5. 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.

____ Date: __________________________
(Parent or Legal Representative)

____ Date: __________________________
(Signature of Witness)