Authorization For The Release and/or Discussion of Protected Health Information

Patient(s) Name: _____

Date of Birth: _____

Authorization: I, _____(Print Name of Parent and/or Guardian) hereby authorize,

Marion Pediatrics, PA
3105 SW 13th Street
Ocala FL 34474
352-369-1001 phone 352-369-0977 fax

their authorized employees and agents to:

☐ Release medical records ☐ Discuss with:

☐ Obtain medical records from ☐ Both release medical records and discuss with:

The following information (specify dates) to be provided:

☐ Complete Medical Record ☐ Labs Diagnostic Testing

☐ Mental Health Treatment (if applicable) ☐ Emergency Room Reports

☐ Other_____ (please specify)

Please Print Name, Address and Phone Number of Previous (or New) Pediatrician Below:

_____

_____

_____

_____

This Disclosure is for the purpose of_____

Signature

I can refuse to disclose some or all of the health care information in my treatment records, but that refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance or other adverse consequences.

I have carefully read and understand the above information, and do herein consent to its disclosure. I am aware that information regarding any medical condition(s) will be released to those persons or agencies named above. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I understand that his consent is subject to revocation, in writing, at any time, unless action based on it has already begun.

I can cross out any provision on this form which I disagree.

I authorize the use of a copy of this form for the disclosure of the information described above.

*****if records are requested by the family and are not picked up within 2 weeks of the original request date, a $5.00 copy records fee will be charged To your account******

Signed_____ Witnessed By: _____

Relationship
To Patient:_____ Date:_____