Office	Address	City	Phone
☐ Big Bend Office	10729 Queens Town Dr	Riverview, FL 33579	(813) 672-3497
☐ Brandon Community Office	811 S Parsons Ave	Brandon, FL 33511	(813) 685-4553
☐ Citrus Park Office	6550 Gunn Hwy	Tampa, FL 33625	(813) 968-2710
☐ Crossroads Office	6671 13th Avenue N #1D	St. Petersburg, FL 33710	(727) 381-1147
☐ FishHawk Office	5621 Skytop Dr	Lithia, FL 33547	(813) 571-6800
☐ Lutz Office	1942 Highland Oaks Blvd	Lutz, FL 33559	(813) 948-6133
☐ North Carrollwood Office	3638 Madaca Lane	Tampa, FL 33618	(813) 968-6610
☐ Northside Office	4446 E Fletcher Ave Ste A	Tampa, FL 33613	(813) 971-6700
☐ South Tampa Office	3222 W Azeele St	Tampa, FL 33609	(813) 872-8491
☐ Suncoast Office	1850 Crossings Blvd #100	Odessa, FL 33556	(813) 475-7100
☐ Walsingham Office	12951 Walsingham Rd	Largo, FL 33774	(727) 391-0158
☐ Wesley Chapel Office	5259 Village Market	Wesley Chapel, FL 33544	(813) 973-0333

Please request to speak with the Records Clerk for any questions or concerns.

Release of Medical Records FROM Pediatric Health Care Alliance

Patient Information

Patient Name: ______________________________ DOB: ___/___/______

Patient Name: ______________________________ DOB: ___/___/______

Patient Name: ______________________________ DOB: ___/___/______

Patient Name: ______________________________ DOB: ___/___/______

If leaving our practice, please indicate reason(s):

- ☐ *Moving out of Tampa Bay area*
- ☐ *Insurance*
- ☐ *Age of patient*
- ☐ *New pediatrician*
- ☐ *Other (please specify):*

____

Release Records TO *(doctor, facility, or individual)*: ______________________________

Address: ______________________________

City / State / Zip: ______________________ Phone: (____)______-________ Fax: (____)______-________

Please identify the information to use, release, obtain or disclose:

☐ Please release entire record

OR

☐ Please release ***only*** the following information *(check appropriate boxes and include other information where indicated)*:

- ☐ Immunization Records
- ☐ Medication List
- ☐ History of Illness
- ☐ Allergy List

☐ Lab Results *(please list dates or types of lab tests you would like disclosed)*:

____

____

☐ Most Recent History

☐ Other *(please specify)*:

____

____

Authorization *(initial each item below)*

____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

This authorization will expire on *(insert date or event)*: ______________________________

If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

The identified information will be used for the following purpose:

☐ My personal records ☐ Sharing with other health care providers as needed ☐ Other: ______________________

______________________ ______________________ ____________

Name (print) **Signature** **Date**

Relationship to Patient: ☐ Self ☐ Parent ☐ Legal Guardian ☐ Other (please specify): ______________________

______________________ ______________________ ____________

Witness Name (print) **Witness Signature** **Date**