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|---|------------------------------------|----------------------------|-----------------------|
| <input type="checkbox"/> Apollo Beach Office | 116 Harbor Village Lane | Apollo Beach, FL 33572 | (813) 493-1779 |
| <input type="checkbox"/> Big Bend Office | 10729 Queens Town Dr | Riverview, FL 33579 | (813) 672-3497 |
| <input type="checkbox"/> Brandon Community Office | 811 S Parsons Ave | Brandon, FL 33511 | (813) 685-4553 |
| <input type="checkbox"/> Central Medical Records | 720 Brooker Creek Blvd, | Oldsmar, FL 34677 | (813) 823-2003 |
| | #215 | Fax: (813) 768-0700 | (813) 278-7858 |
| <input type="checkbox"/> Citrus Park Office | 6550 Gunn Hwy | Tampa, FL 33625 | (813) 968-2710 |
| <input type="checkbox"/> Crossroads Office | 6671 13 th Avenue N #1D | St. Petersburg, FL 33710 | (727) 381-1147 |
| <input type="checkbox"/> FishHawk Office | 5621 Skytop Dr | Lithia, FL 33547 | (813) 571-6800 |
| <input type="checkbox"/> Lutz Office | 1854 Oak Grove Blvd. | Lutz, FL 33559 | (813) 948-6133 |
| <input type="checkbox"/> North Carrollwood Office | 3638 Madaca Lane | Tampa, FL 33618 | (813) 968-6610 |
| <input type="checkbox"/> Northside Office | 4446 E Fletcher Ave Ste A | Tampa, FL 33613 | (813) 971-6700 |
| <input type="checkbox"/> South Tampa Office | 3222 W Azelee St | Tampa, FL 33609 | (813) 872-8491 |
| <input type="checkbox"/> South Manhattan | 4911 S. Manhattan Ave. | Tampa, FL 33611 | (813) 755-4025 |
| <input type="checkbox"/> Suncoast Office | 1850 Crossings Blvd #100 | Odessa, FL 33556 | (813) 475-7100 |
| <input type="checkbox"/> Trinity Office | 1812 Health Care Dr. | Trinity, FL 34655 | (813) 731-0944 |
| <input type="checkbox"/> Walsingham Office | 12951 Walsingham Rd | Largo, FL 33774 | (727) 391-0158 |
| <input type="checkbox"/> Wesley Chapel Office | 5259 Village Market | Wesley Chapel, FL 33544 | (813) 973-0333 |

Release of Medical Records TO Pediatric Health Care Alliance
(Please attach this form when sending medical records)

Please mail full records to the office address checked above or fax records to (813) 768-0700.

*** Immediate: Please fax immunization records only to () - ***

Parent Name: _____ **Contact Phone Number:** _____

Patient Information

Patient Name: _____ DOB: ____ / ____ / ____
 Patient Name: _____ DOB: ____ / ____ / ____
 Patient Name: _____ DOB: ____ / ____ / ____
 Patient Name: _____ DOB: ____ / ____ / ____
 Patient Name: _____ DOB: ____ / ____ / ____

Release Records FROM (doctor or facility name): _____

Address: _____

City / State / Zip: _____ Phone: () - _____ Fax: () - _____

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.

Name (print) _____ **Signature** _____ **Date** _____
Relationship to Patient: Self Parent Legal Guardian Other (please specify): _____

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