PEDIATRIC HEALTH CARE ALLIANCE, P.A.
Your Child's Medical Home™

☐ Apollo Beach Office	116 Harbor Village Lane	Apollo Beach, FL 33572	(813) 493-1779
☐ 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
☐ **Central Medical Records**	**720 Brooker Creek Blvd, #215**	**Oldsmar, FL 34677** **Fax: (813) 768-0700**	**(813) 823-2003** **(813) 278.7858**
☐ 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	1854 Oak Grove 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
☐ South Manhattan	4911 S. Manhattan Ave.	Tampa, FL 33611	(813) 755-4025
☐ Suncoast Office	1850 Crossings Blvd #100	Odessa, FL 33556	(813) 475-7100
☐ Trinity Office	1812 Health Care Dr.	Trinity, FL 34655	(813) 731-0944
☐ Walsingham Office	12951 Walsingham Rd	Largo, FL 33774	(727) 391-0158
☐ 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): _____