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

Release of Medical Records TO Pediatric Health Care Alliance

(Please attach this form when sending medical records)

Please mail full records to: Central Medical Records, 720 Brooker Creek Blvd., Suite 215, Oldsmar, FL 34677

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): ____