Mid-Florida Pediatrics

2340 Glenwood Drive | Winter Park, FL 32792 | (407) 975-0681 | (407) 975-0683 fax

AUTHORIZATION TO RELEASE INFORMATION

PLEASE PRINT CLEARLY

Patient Name _____
LAST FIRST MID INITIAL

Address _____
STREET CITY STATE ZIP

Phone (____)_____ Date of Birth _____ Record # _____

I authorize _____ to release medical information from my medical record to: **Mid-Florida Pediatrics, PA, 2340 Glenwood Dr, Winter Park, FL 32792**

For the purpose of review/examination and further authorize you to provide such copies thereof as many be requested. The foregoing is subject to such limitation as indicated below:

☐ Entire Record

☐ Specific Information: _____

☐ Old Records from Previous Physicians

I give special permission to release any information regarding: (initial on the line(s) below that you grant us permission to release the information to the above)

___Substance Abuse ___Psychiatrics/Mental Health Information ___HIV Information

This authorization will automatically expire one year from the date signed. I understand that I may revoke this consent at any time except to the extent that action has been taken to reliance thereon.

Reason for Request:_____

Signed:_____
_
(IF NOT PATIENT, STATE RELATIONSHIP)

Witness: _____

FOR OFFICE USE ONLY

Received: _____ Completed by: _____

Completed: _____ Fee Paid: _____

Disclosure consisted of:

_____