



AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS

Patient name: _____ Date of birth: _____

Current Phone: _____

Current Address: _____

RELEASE MEDICAL RECORDS FROM:

DISCLOSE MEDICAL RECORDS TO:

Name or Facility: _____

Name or Facility: Advanced Kids Care

Address: _____

Address: 98 Terra Mango Loop, Unit 12, Orlando, FL 32835

Phone: _____ Fax: _____

Phone: 407-612-4007 Fax: 407-612-4017

I AM REQUESTING MEDICAL RECORDS FROM DATES: FROM: _____ TO: _____

Please send my requested information by:

Fax: _____ Mail: _____ Email: _____

Note: It is preferred to send records via fax.

I authorize the following types of information to be released:

- | | |
|---|---|
| <input type="checkbox"/> All medical records | <input type="checkbox"/> Operative Notes |
| <input type="checkbox"/> Labs/Pathology/Imaging | <input type="checkbox"/> Growth Charts |
| <input type="checkbox"/> Immunizations/Vaccines | <input type="checkbox"/> Medications |
| <input type="checkbox"/> History/Physicals | <input type="checkbox"/> Photos |
| <input type="checkbox"/> Specialist Consultations | <input type="checkbox"/> Billing Statements |
| <input type="checkbox"/> Hospital Records | <input type="checkbox"/> Other: _____ |

Your initials are required to release the following:
_____ Psychiatric/Psychological Evaluations or Notes
_____ Drug/Alcohol Results
_____ HIV/STD Report
*If requesting adolescent encounters minor must sign:

Purpose of Disclosure: (Please specify):

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> Transfer of Care | <input type="checkbox"/> Personal Use |
| <input type="checkbox"/> Continuity of Treatment | <input type="checkbox"/> Other: _____ |

Expiration date: _____
*If left blank, this authorization will expire one year from the date signed.

I recognize that the health information disclosed may contain information that is privileged and protected by law and I specifically consent to the disclosure of such information. I understand I have the right to inspect or copy the information to be used/disclosed as permitted by federal law. All records obtained will be used solely for professional purposes and will remain confidential and may not be disclosed to third parties. This authorization may be revoked by me in writing to Advanced Kids Care at any time. A written cancellation in the future will have no effect on any records that may have been released prior to the receipt of the written cancellation. Information released may be subject to re-disclosure by the recipient. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected. I understand that a copy of this release is as valid as the original and I may also receive a copy of this form after I sign it. In consideration of this consent, I hereby release the above parties from any and all liability arising there from.

Signature of Patient/Parent/Legal Guardian:

Print Name of Patient/Parent/Legal Guardian:

Date: _____

Relationship to patient: _____