



Pediatrics Division

Authorization for Release of Medical Record Information:

Patient's Legal Name: _____ Date of Birth: _____

I Authorize the Following Provider to Release my Protected Health Information:

Name: _____

Address: _____

Telephone: _____ Fax: _____

Information released to:

Name: _____

Address: _____

Telephone: _____ Fax: _____

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

Information to be disclosed - **Last two years of records will be provided unless otherwise noted below

- Office Notes, Diagnostic Reports, Laboratory Reports, Last two years of Health Record, Immunization Record, Growth Chart, Other

Reason for disclosure:

- Continuation of Treatment, Legal or Insurance, Payment, Personal, Other

Are you leaving the practice? Yes No

I understand that this authorization will NOT include the following information unless indicated and initialed below:

- AIDS or HIV Infection, Sexually Transmitted Disease Information, Behavioral Health Care/Mental Health Services, Treatment for alcohol and/or drug abuse

As described in the Notice of Privacy Practices of Physicians' Primary Care of Southwest Florida, I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Physicians' Primary Care of Southwest Florida in reliance on this authorization, by sending a written revocation to Physicians' Primary Care of Southwest Florida, 12730 NEW BRITTANY BLVD, SUITE 602, FORT MYERS, FL 33907, ATTENTION: Privacy Officer

I understand that this authorization is valid for up to six months from the date I sign it unless I specify otherwise. I also understand that I may be charged for copies of my medical records as allowable under Florida Administrative Code Rule: 64B8-10.003. Further, I understand that I will not be denied or refused treatment if I refuse to sign this authorization.

Signature of Patient or Legal Representative Date Relationship to Patient

Signature options: Cape Coral, Florida 33990 (1261 Viscaya Parkway, Suite 101; 1265 Viscaya Parkway); Fort Myers, Florida 33919 (9350 Camelot Drive); Lehigh Acres, Florida 33971 (5700 Lee Blvd). Includes phone and fax numbers for each location.