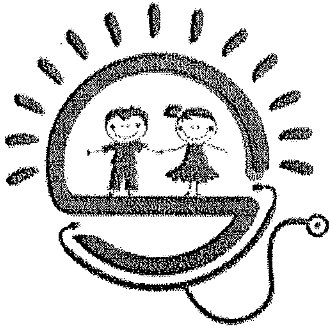

Sunshine Pediatrics of Lutz

18934 N. Dale Mabry Hwy, Suite 101

Lutz, Florida 33548

(813) 948-2679 phone □ (813) 948-2694 fax

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: ______________________________ MRN# ______________

SSN: ______________________________ DOB: ______________

1. I authorize the use of disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:
   Name of previous physician ______________________________
   Address: ______________________________ Phone: ______________
   ______________________________ Fax: ______________
3. The type and amount of information to be disclosed is as follows:

	Complete Medical Record		List of allergies		X-Ray Reports
	Physician Progress Notes		Problem List		EKG
	Immunization Record		Lab Reports		Medication List
	Consultation Reports from:				Other

4. Unless otherwise provided by law, records and information concerning the following types of diagnoses, care and treatment will be released only if I indicate my specific consent by checking the appropriate box.

	Alcohol Abuse		Mental Health Notes		Drug/Substance Abuse
	Testing for HIV antibodies and/or treatment of AIDS				

5. This information may be released to and used by the following individual(s) or organization(s):
   Name: ______________________________
   Address: ______________________________
   For the purpose of: ______________________________
6. I understand that I have a right to cancel this authorization at any time. I understand that if I wish to withdraw this authorization I must do so in writing. I must present my written cancellation to the health information management department. I understand that the authorization withdrawal will not apply to information that has already been released due to this authorization. I understand that the cancellation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise cancelled, this authorization will expire on the following date, event or condition: ______________________________.
   If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months.
7. I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I don't have to sign this form to receive treatment. I understand that I may inspect or copy the information (for a nominal fee) to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information any not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact my physician's office manager.

______________________________ ______________

Signature of Patient/Legal Representative (Specify relationship to patient) Date

FOR OFFICE USE ONLY

Purpose for transfer: ☐ Insurance Change ☐ Relocation ☐ Other Compliant with HIPAA Regulations