Island Pediatrics
4611 Highway 17, Suite 2
Fleming Island, FL 32003
Ph: (904) 264-4333 Fax (904)264-4301

Authorization for Release of Protected Health Information

Patient's Name_____ DOB _____

Patient's Name _____ DOB _____

Parent/Guardian Name_____Phone_____

Copies of patient's medical record to be released:

FROM:_____ TO:_____
_____ _____
_____ _____

For the specific purposes I have checked below:

☐ Changing primary care physician and discontinuing care at this office

☐ Leaving town and transferring records to my new physician

☐ Personal reasons

☐ Other: _____

ALL PATIENT INFORMATION IS CONFIDENTIAL AND PRIVILEGED

The confidentiality of patient records is protected by Federal Law. Federal Law prohibits the recipient from making any further disclosure. A general authorization for the release of medical information is NOT sufficient for this purpose.

I agree to hold Island Pediatrics harmless from any and all costs, liability and damages of any nature whatsoever including reasonable attorney's fees, resulting directly or indirectly from the release of my medical records pursuant to this content.

AS PART OF THE MEDICAL RECORD, THE FOLLOWING INFORMATION WILL BE RELEASED UNLESS STRICKEN:

SEXUAL ABUSE INFORMATION
DRUG ABUSE INFORMATION
CHILD ABUSE AND NEGLECT INFORMATION
PSYCHIATRIC INFORMATION
AIDS / HIV INFORMATION

I acknowledge that I have read this authorization and fully understand its contents.

Signed: _____ Date: _____
(Patient, Parent or Guardian)

Signed: _____ Date: _____
(Witness)

***For office use**: Information was MAILED/PICKED UP by _____ on _____*