



Pediatric Associates
of Jacksonville
Dr. O.

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Sutton Park Court, Suite 801 • Jacksonville, FL 32224 • 904-743-2100 *tel* • 904-743-1759 *fax* • 1633 Race Track Rd,
Suite 103 • Jacksonville, FL 32259 • 904-287-7000 *tel* • 904-460-2212 *fax*

Authorization to Release Confidential Information

I, _____, hereby authorize _____

Previous facility name

at _____

Previous Facility Address, Phone & Fax Number

to release **ALL** medical records *(which might include psychiatric, AIDS, sexually transmitted disease, pregnancy, alcohol, and/or drug abuse information contained in the requested records) to:

PEDIATRIC ASSOCIATES OF JACKSONVILLE, P.A.

located at:

1102 A1A N Unit 104 Ponte
Vedra Beach, FL 32082
Phone: 904-273-6533
Fax: 904

Julington Creek
1633 Race Track Rd, Suite 103
Jacksonville, FL 32259

Phone: 904-287-7000
Fax:904-460-2212

Hodges
4745 Sutton Park Court, Suite
801 Jacksonville, FL 32224

Phone: 904-743-2100
Fax:904-743-1759

for the purpose of: _____

*Specify the purpose of disclosure of records ***MUST BE COMPLETED****

I understand that the specific reports shall include ***ALL RECORDS*** as indicated, for:

Name of Patient

Date of Birth

I understand this consent is revocable upon written notice, except to the extent that action by Pediatric Associates of Jacksonville has been taken in reliance on this authorization, and this authorization shall remain in force for a six-month period in order to affect the purpose for which it is given. Alcohol and drug abuse information, if present, has been disclosed from records whose confidentiality is protected by Federal Law. Federal Regulations 42CFR, Part 11 prohibits making any further disclosure of records without the specific written authorization of the undersigned, or as otherwise permitted by such regulations. The confidentiality of HIV antibody test results is protected by Florida

Law, (Florida State Amnesty 381.609 (2) (f)) which prohibits any further disclosure by a person to whom this information has been disclosed, without the specific written consent of the undersigned or as otherwise permitted by State Law. I understand that if I consent to the release of any of these medical records, the results of any HIV antibody testing are included in the medical records.

***BEFORE SIGNING, CROSS OUT ANY PART(S) THAT DO(ES) NOT APPLY**

Date of Authorization

Parent, Legal Guardian, or Authorized Signature & Relationship to patient

Expires

Witness

Patient's Signature (if required)