Pediatric Associates of Jacksonville

Authorization to Release Confidential Information

I, _____, hereby authorize _____
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 (select office)

( ) 1102 A1A N Unit 104 • Ponte Vedra Beach, FL 32082 • Phone: 904-273-6533 • Fax: 904-273-6532

( ) 4745 Sutton Park Court, Suite 801 • Jacksonville, FL 32224 • Phone: 904-743-2100 • Fax: 904-743-1759

( ) 1633 Race Track Rd, Suite 103 • Jacksonville, FL 32259 • Phone: 904-287-7000 • Fax: 904-460-2212

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(s) **Date of Birth**

_____

_____

_____

( ) I request the following record(s) on the above patient(s) _____ ALL _____ Service Date

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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)