Ocala Pediatrics
1500 S.E. 17th Street, Bld 600
Ocala, FL 34471
352-732-8955
Fax 352-732-7999

# AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

1. **PATIENT INFORMATION:**

Last First Middle Date of Birth SSN

Street Address City State Zip Code

2. **INFORMATION TO BE RELEASED TO:**

Name (Facility, Agency, etc.)

Street Address

City State Zip Code

Phone and Fax Number (Including Area Code)

3. **INFORMATION TO BE RELEASED FROM:**

Name (Facility, Agency, etc.)

Street Address

City State Zip Code

Phone and Fax Number (Including Area Code)

4. **THIS INFORMATION SHOULD INCLUDE THE FOLLOWING: Please initial each item to be released.**

___ Clinic Notes/Office Visits ___ Immunizations ___ Growth Chart
___ In Office Laboratory Reports ___ Radiology Report ___ Other_____

5. **NOTICE:** This authorization is for **FULL DISCLOSURE OF ALL RECORDS**, including clinical findings, diagnosis, treatment, assessment, recommendations for further care, names of health care personnel, dates of visits, charges, and any other information that may be related to drug, alcohol, psychiatric conditions, and/or sexually transmitted disease, including HIV/AIDS information. Such records will be disclosed unless specified information to exclude is listed below.

**EXCLUSIONS:** _____

6. **PURPOSE OF DISCLOSURE:** ___ Continuing Treatment ___ Insurance ___ Personal Use ___ Other (Specify)

7. **REDISCLOSURE:** I understand the recipient of this information may not use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

8. I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 90 days from the date of signature. I understand I may cancel this request with written notification but that it will not have any effect on information released prior to this notification.

**SIGNATURE OF PATIENT/**
**LEGAL AUTHORITY:** _____ **DATE:** _____

**LEGAL AUTHORITY IS:** ___ Guardian ___ Parent of Minor ___ Attorney ___ Next of Kin ___ Executor of Estate ___ Other

**SIGNATURE OF WITNESS:** _____ **DATE:** _____

**HEALTH INFORMATION REQUESTED ABOVE WAS RELEASED BY:** _____
Name Date