



<input type="checkbox"/> Apollo Beach Office	116 Harbor Village Lane	Apollo Beach, FL 33572	(813) 493-1779
<input type="checkbox"/> Big Bend Office	10729 Queens Town Dr	Riverview, FL 33579	(813) 672-3497
<input type="checkbox"/> Brandon Community Office	811 S Parsons Ave	Brandon, FL 33511	(813) 685-4553
<input type="checkbox"/> Citrus Park Office	6550 Gunn Hwy	Tampa, FL 33625	(813) 968-2710
<input type="checkbox"/> Crossroads Office	6671 13 th Avenue N #1D	St. Petersburg, FL 33710	(727) 381-1147
<input type="checkbox"/> FishHawk Office	5621 Skytop Dr	Lithia, FL 33547	(813) 571-6800
<input type="checkbox"/> Lutz Office	1942 Highland Oaks Blvd	Lutz, FL 33559	(813) 948-6133
<input type="checkbox"/> North Carrollwood Office	3638 Madaca Lane	Tampa, FL 33618	(813) 968-6610
<input type="checkbox"/> Northside Office	4446 E Fletcher Ave Ste A	Tampa, FL 33613	(813) 971-6700
<input type="checkbox"/> South Tampa Office	3222 W Azeele St	Tampa, FL 33609	(813) 872-8491
<input type="checkbox"/> Suncoast Office	1850 Crossings Blvd #100	Odessa, FL 33556	(813) 475-7100
<input type="checkbox"/> Trinity Office	1812 Health Care Dr.	Trinity, FL 34655	(813) 731-0944
<input type="checkbox"/> Walsingham Office	12951 Walsingham Rd	Largo, FL 33774	(727) 391-0158
<input type="checkbox"/> Wesley Chapel Office	5259 Village Market	Wesley Chapel, FL 33544	(813) 973-0333

Please ask for the Records Clerk for any questions or concerns.

Release of Medical Records FROM Pediatric Health Care Alliance

Patient Information

Patient Name: _____ DOB: ____/____/____
 Patient Name: _____ DOB: ____/____/____
 Patient Name: _____ DOB: ____/____/____
 Patient Name: _____ DOB: ____/____/____

If leaving our practice, please indicate reason(s):

- Moving out of Tampa Bay area
- Insurance
- Age of patient
- New pediatrician
- Other (please specify): _____

Release Records TO (doctor, facility, or individual): _____

Address: _____

City / State / Zip: _____ Phone: (____) _____ - _____ Fax: (____) _____ - _____

Please identify the information to use, release, obtain or disclose:

Please release entire record
OR

Please release **only** the following information (check appropriate boxes and include other information where indicated):

- | | | |
|---|--|--|
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Lab Results (please list dates or types of lab tests you would like disclosed): _____ | <input type="checkbox"/> Most Recent History |
| <input type="checkbox"/> Medication List | | <input type="checkbox"/> Other (please specify): _____ |
| <input type="checkbox"/> History of Illness | _____ | |
| <input type="checkbox"/> Allergy List | _____ | |

Authorization (initial each item below)

_____ I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment.

This authorization will expire on (insert date or event): _____

If I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.

The identified information will be used for the following purpose:

- My personal records Sharing with other health care providers as needed Other: _____

Name (print)

Signature

Date

Relationship to Patient: Self Parent Legal Guardian Other (please specify): _____

Witness Name (print)

Witness Signature

Date