* NO CD'S *

VERO BEACH PEDIATRICS

Email Form To: careteam@verobeachpediatrics.com

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Information: I give permission to release the health information of:

Patient Name:	D.O.B.
Address:	
City, State, Zip:	Telephone:
Email Address:	

RELEASE INFORMATION FROM:

(Name of facility, person, company)

(Street address or PO Box, City, State, Zip)

(Telephone number) (Fax number)

RELEASE INFORMATION TO:

VERO BEACH PEDIATRICS
(Name of facility, person, company)

959 37TH PLACE, VERO BEACH, FL 32960
(Street address or PO Box, City, State, Zip)

772-569-3212 772-569-1435 FAX
(Telephone number) (Fax number)

Dates of treatment for records to be released: Treatment dates from: ___ / ___ / ___ to: ___ / ___ / ___

Hospital Abstract (check all that may apply)

☐ Consultation reports ☐ Diagnostic Test Results ☐ Medications ☐ History & Physical ☐ Discharge Summary ☐ Operative Reports Substance ☐ Abuse Records

☐ Allergies ☐ Physician Orders ☐ Progress Notes ☐ Emergency Record ☐ Cardiac Reports/EKG ☐ Laboratory Reports ☐ Mental Health ☐ HIV/AIDS Information

☐ Radiology/XRay Reports ☐ Pathology Reports ☐ Billing Information ☐ Mental Health Records ☐ Developmental Disability Records ☐ Therapy Notes

☐ Other: _____

☐ Entire Record (not including psychotherapy notes)

Office/Clinic Abstract (check all that may apply)

☐ Office Visits ☐ Physical Exam ☐ Consultation Reports ☐ Diagnostic Test Results ☐ Laboratory Reports ☐ Medications ☐ Billing Information

☐ Mental Health ☐ Developmental Disability Records ☐ Substance Abuse Records ☐ HIV/AIDS Information ☐ Therapy Notes

☐ Other: _____

☒ Entire Record (not including psychotherapy notes)

To be completed by requester: (select one) **Delivery Method:**

☐ Paper Copy D Electronic Copy ☐ US Mail ☐ Pick-up ☐ Fax ☐ e-Mail:

☐ CD (Charges may apply) ☐ Other: ☐ Other:

I have read this authorization form and understand the following statements:

I understand this Authorization will expire on ___ / ___ / ___ or when the following event occurs:

Note: If authorization is for disclosure of mental health records, it must have a calendar date expiration, or the information may only be disclosed on the current day.
Note: If this authorization is for research, an expiration date is not required.

- I am giving the Office Practice permission to release my health information.
- I understand that I may cancel this permission at any time by notifying the Office Practice ins writing, but if I do, it will not impact any actions the Office Practice took before I canceled this authorization.
- I understand that permitting the release of my health information is my choice. I can refuse to give permission for releasing my health information. I understand the
- Office Practice may not require me to sign this form before I am treated. I understand that any health information released could then be shared again with another person or entity and that my health information may not be protected by federal law.
- I understand the Office Practice may be allowed by law to deny my request lo access or receive a copy of all or part of my health information and that I will receive a written notice explaining why my request was denied.
- I understand I may have to pay for a copy of my records.
- I understand I may receive a copy of this signed authorization form.

I have read this form and agree to the release of my health information as written above.

Patient Signature: _____
Printed Name of Authorized Representative/Parent: _____
Relationship to Patient: _____
Address and Phone Number of Authorized Representative/Parent: _____

FOR OFFICE USE ONLY

Date of Release ___ / ___ / ___ ☐ US Mail ☐ Pick-up ☐ Fax ☐ e-Mail: _____ ☐ Other: _____ ☐ ID Verified ☐ DL/ID: _____

Employee Name & Title _____ Employee User ID: _____ Date: ___ / ___ / ___

Note to recipient of alcohol or drug abuse records: This information has been disclosed to you from records protected by federal confidentiality rules (42 CRF Part 2). The federal rules prohibit you for making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient