TRANSFER INTO

PENSACOLA PEDIATRICS, P.A.

PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION and REQUEST FOR RELEASE OF MEDICAL RECORDS

To: _____
PHYSICIAN'S NAME

_____ _____ _____ _____
ADDRESS CITY STATE ZIP

_____ _____
PHONE NUMBER FAX NUMBER

I HEREBY REQUEST THAT MY CHILD'S MEDICAL RECORDS BE RELEASED TO:

PENSACOLA PEDIATRICS, P.A. *(Circle Location)*

5755 Quintette Rd
Pace, FL 32571
(850) 995-8087
(850) 994-5292 Fax

5834 Berryhill Rd
Milton, FL 32570
(850) 623-5437
(850) 626-7803 Fax

_____
PATIENT'S NAME Date of Birth

I authorize you to use and/or disclose certain protected health information (PHI) about me to Pensacola Pediatrics, P.A.

- ❑ All Office Records
- ❑ Immunization Record Only
- ❑ Discharge Summary Only
- ❑ ER/Urgent Care Visit including Lab/Xray Results
- ❑ Newborn Records to include H&P, Hepatitis B Immunization Record, Obstetrical Nursing Assessment, Labs and D&C Summary if applicable.
- ❑ Other

This information will be used or disclosed for the following purpose:
AT THE REQUEST OF THE INDIVIDUAL

This authorization will expire upon receipt of these records at Pensacola Pediatrics.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing expect to the extent the practice has acted in reliance upon this authorization. My written revocation must be submitted to the HIPAA privacy Officer at Pensacola Pediatrics, 4951 Grande Drive, Pensacola, FL 32504. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

___ I DO _____ I DO NOT authorize the release of information, including, if applicable, specific laboratory test of HIV infection (Human Immunodeficiency Virus, the causative agent of AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions, all medical records or other information regarding my treatment, hospitalization including psychological or psychiatric impairment, drug abuse and/or alcoholism or sickle cell anemia.

Phone: _____

Signed by: _____ _____ _____
Signature Print Name Date