TRANSFER FROM

PENSACOLA PEDIATRICS, P.A.

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

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

_____
RECIPIENT'S NAME

_____ _____ _____ _____
ADDRESS CITY STATE ZIP

_____ _____
PHONE NUMBER FAX NUMBER

_____
PATIENT'S NAME Date of Birth

_____
PATIENT'S NAME Date of Birth

I authorize you to use and/or disclose certain protected health information (PHI) about me to my new physician.

- ❑ All Office Records
- ❑ Immunization Record Only
- ❑ 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 _____.

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 except 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.

__ 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