PEDIATRICS IN BREVARD

MEDICAL RECORDS RELEASE AUTHORIZATION ---- PLEASE PRINT CLEARLY

Patient's Full Name: _____ Date of Birth_____

Address: _____ City:_____

St: _____ Zip: _____Cell Phone: _____ Work Phone:_____

PLEASE CHECK ONE:

Sending Records to: _____ OR Obtaining Records from: _____

PLEASE CHECK ONE:

Primary Care Physician: _____ OR Specialist: _____

Physician/Facility Complete Name: _____

Address: _____ City:_____

St: _____ Zip: _____ Phone: _____Fax:_____

Please send all pertinent records Initial _____ Other Specify: _____

Reason for transfer: _____

The patient or patient's representative must read and initial the following statements:

I understand the health record may include information relating to sexually transmitted diseases, AIDS, or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and/or drug abuse. **Initial** _____

This authorization will expire in 12 months if a date is not specified. **Initial** _____

I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. **Initial** _____

Pediatrics in Brevard will not condition my child's treatment on my completing and signing this authorization. **Initial** _____

Signature of Patient/ Patient's representative: _____Date_____

Relationship to Patient: _____

Reply to :

_____ 134 S. Woods Dr., Rockledge, FL 32955 321-636-3066 Fax 321-636-2545
_____ 1755 W Hibiscus Blvd., Melbourne, Fl 32901 321-724-5437 Fax 321-724-5570
_____ 699 W. Cocoa Beach Cswy Ste. 401, Cocoa Beach, Fl 32931 321-784-5437 Fax 321-799-1231
_____ 7332 Office Park Place Ste. 103, Viera, Fl 32940 321-435-9800 Fax 321-435-9803

Revised 7/8/2014
Approved by: DSapp