AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PATIENT INFORMATION

Pediatric Partners
3401 PGA Blvd # 300
Palm Beach Gardens, FL 33410
Phone Number: (561) 741-0000
Fax Number: (561) 741-0002

Pediatric Partners
1025 Military Trail #109
Jupiter, FL 33458
Phone Number: (561) 741-0000
Fax Number: (561) 741-0002

Pediatric Partners
5458 Town Center Rd #101
Boca Raton, FL 33486
Phone Number: (561) 393-8555
Fax Number: (561) 393-1904

Patient Name _____

DOB:_____ Telephone Number: _____

Purpose of Release:_____

I HERBY AUTHORIZE PEDIATRIC PARTNERS TO RELEASE MEDICAL INFORMATION TO:

Name: _____

Address: _____

City:_____State:_____Zip: _____

**Full Medical Record – No charge if records are released to another physician
$1.00 per page first 25 pages $0.25 per page thereafter if released to Parent

Immunization Record

Physical Exams and Growth Charts

Specific Items

Requested_____

Any information including diagnosis and records of any treatment or examination rendered to me including any Federal and State protected information under appropriate statute, Mental Health, Psychotherapy, Substance Abuse, Human Immunodeficiency Virus (AIDS) tests results and treatment. I understand that this authorization will remain in effect for six (6) months or until I revoke it in writing to an authorized employee of Pediatric Partners.

I have read Pediatric Partners' Notice of Privacy. I hereby release Pediatric Partners and its employees from any and all liability that may arise from the release of information as I have directed.

_____ _____
Signature of Patient Date

_____ _____ _____
Signature of Empowered Representative Relationship to Patient Date