



**AUTHORIZATION FOR RELEASE OF
CONFIDENTIAL PATIENT INFORMATION**

To: _____
Doctor or Hospital

Address: _____

PATIENT'S NAME: _____ DOB: _____

SS#: _____ Telephone Number: _____

Purpose of
Release: _____

I hereby authorize and request release of the following information to Pediatric Partners:

- Full Medical Record
- Immunization Record
- Physical Exams and Growth Charts
- Specified Items Requested _____
- _____

Please mail the requested information to:

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 Road #101
Boca Raton, FL 33486
Phone Number: (561) 393-8555
Fax Number: (561) 393-1904

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