



**AUTHORIZATION FOR RELEASE OF
CONFIDENTIAL PATIENT INFORMATION**

To: _____
Doctor or Hospital

Address: _____

Telephone Number: _____ Fax Number: _____

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
PO Box 9168
Jupiter, FL 33468-9168

Office: 561-741-0000
FAX: 561-741-0002**

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

Boca Raton • Palm Beach Gardens • Jupiter
PO Box 9168, Jupiter, FL 33468-9168
Office: 561-741-0000 • FAX: 561-741-0002
www.pediatricpartners.com