Pediatric Partners
with you, for your child... for years to come.

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 fax or email the requested information to:

Pediatric Partners
Office: 561-741-0000
FAX: 561-741-0002

PRINTED COPIES OF MEDICAL RECORDS WILL NOT BE ACCEPTED

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