

**Medical Records Release**  
Premier Pediatrics  
10,000 West Colonial Drive, Suite 390  
Ocoee, FL 34761  
407-290-2394  
Fax 407-521-3640

**Request for Access and Authorization for Use and/or Disclosure of Protected Health Information**

Please allow a minimum of two business days to process your request.

I understand that the protected health information specified below may include mental health, substance abuse (e.g., drugs, alcohol) HIV/AIDS status information, diagnostic and treatment records.

I have read and understand the following statements:

1. I may revoke this authorization at any time by notifying Premier Pediatrics in writing.
2. I understand that my revocation does not affect any disclosure made prior to the revocation being received and processed.
3. I understand the information disclosed may be subject to redisclosure and no longer be protected by federal or state privacy laws.
4. I understand that I am signing this form voluntarily and I am signing this under my own free will. Premier Pediatrics will not condition my treatment, payment, enrollment in health plans or my eligibility for benefits by signing this form.
5. I understand that I will receive a signed copy of this form, if requested
6. I further agree to pay charges to provide the information requested per the Florida Statutes
7. I understand that unless otherwise revoked, this authorization will expire upon the following date, event or condition: \_\_\_\_\_ . If no expiration date, event or condition is noted this authorization will expire 1 year from the date signed.

I understand and agree to the provisions of this form on behalf of the individual patient indicated below. I have signed my name individually as the parent of the patient, as the patient, or as the legal guardian of the patient. If I am the legal guardian, I have attached a copy of the court order designating me as the guardian of the patient.

**Patient's Legal Name:** \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient/Parent/Legal Guardian Phone Number: \_\_\_\_\_

I authorize Premier Pediatrics to: Disclose to: \_\_\_\_\_

or

**Obtain from:** (previous doctor) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**Phone:** \_\_\_\_\_ **FAX:** \_\_\_\_\_

The purpose of this request:

Personal Request \_\_\_\_\_ Treatment (Continued Care) \_\_\_\_\_

Other: \_\_\_\_\_

Please furnish the following information specified below for the following dates: \_\_\_\_\_

Circle one:

shot record only, Complete chart, Other: \_\_\_\_\_

Parent/Guardian/Adult Patient **Signature:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Date :** \_\_\_\_\_

Per Florida Statute 456.057 and Department of Health Chapter 64B8-10.003 reasonable costs of reproducing copies of written or typed documents or reports shall not be more than the following: For the first 25 pages, the cost shall be \$1.00 per page. For each page in excess of 25 pages, the cost shall be 25 cents per page.