



PLEASE RETURN THIS FORM
TO THE RECEPTIONIST WHEN
COMPLETE.

MEDICAL RELEASE FORM

Sunshine Pediatrics - Authorization for Release of Information

Patient Name (First, MI, Last): _____

Address/City/State/Zip: _____

Phone Number: (____) _____ Date of Birth: _____

This Authorization applies to the following Information:

All Information. I understand that the information may contain psychiatric/psychological, alcohol/drug abuse, and/or AIDS/HIV information and I expressly consent to the release of the information.

Only the following records or types of Information: _____

Treatment Dates: from (month/day/year) _____ / _____ / _____ to (month/day/year) _____ / _____ / _____

<i>I consent for my child's medical records to go:</i>	
To: Practice Name: Address: _____ City/State/Zip : _____ Phone: (____) _____	From: Practice Name: Address: _____ City/State/Zip : _____ Phone: (____) _____
From: Origin Name: _____ Address: _____ City/State/Zip: _____ Phone: _____	To: Origin Name: _____ Address: _____ City/State/Zip: _____ Phone: _____

Purpose of the release: Continuity of Treatment Other (Please specify _____)

I understand the Information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the disclosure of Information to a recipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), then the recipient may re-disclose it and it may no longer be protected under HIPAA, a federal privacy law. This Authorization is valid for ninety (90) days from the date of signature, unless otherwise noted. This Authorization only applies to treatment occurring before the date of signature. I may decline to sign this Authorization. I understand I may revoke this authorization in writing at any time by completing a form available from Sunshine Pediatrics. If I revoke this authorization, the revocation will not apply to information that has already been released in response to this authorization. I understand the patient's health care and the payment for the patient's health care will not be affected if I do not sign this form. I understand I may see and copy the Information described on this form if I ask for it, and I may receive a copy of this form after I sign it. Before requesting medical record copies, please ask about the copy fee by law that may apply. I represent that I have the authority to and voluntarily grant permission for the Information to be released as described above.

Patient/Parent/Legal Guardian Printed Name

Patient/Parent/Legal Guardian Signature Date

Patient Signature if Adult (ie.19 or older) Date
HIPAA Authorization specific request 6-26-12

Witness Signature Date