Dr. Lozano, Dr. D' Souza, Dr. Luke, Jennifer Sibley, CPNP

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION FROM ORMOND PEDIATRICS PA

Date:________

Patient's Name: ____ DOB: ___________

Address:____

The information to be released includes: Entire medical Record

Other: ____

Healthcare information will be used and/or disclosed for the following purpose(s):

_____Changing Primary Care Physician _____ seeing/ Changing Specialist

_____ Other(Write purpose here): ____

I request and authorize Ormond Pediatrics, PA to Release healthcare information of the patient named above to:

Doctor/Office Name: ____

Phone Number:_____________________ Fax Number:________________________

Address:____

Please exclude the following information if it is part of my child's Medical Records:

_____ Chemical Dependency/Substance Abuse
_____ Psychiatric/Psychological Conditions
_____ Sexually Transmitted Disease
_____ Alcohol/Drugs

Parent/ Legal Guardian Name: ____
Parent/ Legal Guardian Signature: ____________________________________