MEDICAL RECORDS RELEASE FORM

PEDIATRIC ASSOCIATES

PLEASE COMPLETE ONE FORM PER CHILD

Patient Name: ______________________ **Date of Birth:** ______________________

Patient Address: ______________________ **Account /Chart:** ______________________

Street Address

______________________ **Phone #** ______________________

City, State, Zip

I authorize: **To release the above patient's medical records to:**

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Primary Care Provider (PCP) or Specialist's Name **New PCP, Specialist, or Person Receiving Copy**

______________________ ______________________

Street Address **Street Address**

______________________ ______________________

City, State, ZIP **City, State, ZIP**

______________________ ______________________

Phone number **Phone number**

By signing this authorization, I authorize the above listed PCP or specialist to disclose certain protected health information (PHI) about the patient listed above. I also understand that I may revoke this authorization at any time in writing, to the address listed below, provided the information has not been released.

There will not be any charge for medical records that are sent from PCP or specialist to PCP or specialist

There will be a monetary charge for medical record that will be sent from PCP or specialist to a patient or a patient's legal guardian, as described below

( ) **Paper** and/or ( ) **Electronic**

I understand and agree that I am financially responsible for the following fees associated with my request for medical records to be sent from the PCP or specialist to me, the patient, or to me, the patient's legal guardian:

Copying charges include the cost of supplies, electronic devices, labor related to the production of this information and postal charges.

I understand that the charge for paper copy is: **$1 each page for the first 25 pages, then $.25 for each page thereafter.**
I understand the charge for an electronic copy: **$20 including the cost of an encrypted CD.**
I understand the charge for **digital radiology image copies onto a CD: $10**
(Costs for reproducing medical records are in accordance with the FL Administrative Register Rule 64B8-10.003 and F.S. 164.524 ©4.)

***Please indicate the specific information to be released*:**

( ) **Complete medical record** – to be requested from a previous PCP or specialist when you are a new patient to Pediatric Associates

( ) Other: ______________________

***Please indicate any information that you want excluded /not released with your request*:**

( ) Mental Health Records ( ) Drug/Alcohol Treatment ( ) HIV Testing ( ) Sexual Assault/Victimization Records

( ) Other: ______________________

Please indicate the reason you are requesting medical records to be released:

( ) Personal copy (***charges apply)*** ( ) Transitioning to an adult PCP/specialist ( ) Continuity of Care ( ) Change of Insurance
( ) Referral to Specialist ( ) Moving out of state ( ) Leaving Practice ( ) Unhappy due to wait time
( ) Unhappy due to Customer Service ( ) Unhappy with PCP/specialist (Please state why) ______________________
( ) Unhappy with Practice (Please state why) ______________________

***Inspection requests are valid on the date of signature only / Release or Copy requests expire 90 days from signature date**
***Please allow up to 30 days for processing**

______________________ ______________________ ______________________

Signature of Patient or Legal Guardian Printed Name of Patient or Legal Guardian Date

ADMINISTRATIVE OFFICE: 900 S. Pine Island Rd, Suite 800 • Plantation, FL 33324 • Tel: (954) 967-6400

Prohibition of Re-disclosure: This information has been disclosed to you from records whose confidentiality is protected by law. Any further disclosure is strictly prohibited unless the patient/legal guardian provides specific written consent for subsequent disclosure of this information. These records may be protected by federal regulation (42 CFR, Part 2).