ALL My Kids PEDIATRICS
515 N. Park Ave
Apopka, Fl 32712
Ph: (407) 814-4934
Fax: (407) 814-4936

AUTHORIZATION FOR REVIEW/RELEASE OF PROTECTED HEALTH INFORMATION (MEDICAL RECORDS)

PATIENTS NAME: _____ **D.O.B**_____

PHYSICIAN/HOSPITAL NAME: _____

ADDRESS: _____ **PHONE:** _____

_____ **FAX:** _____

INFORMATION MAY BE DISCLOSED TO: ALL MY KIDS PEDIATRICS, LLC.

THIS AUTHORIZATION WILL EXPIRE ON_____/_____/_____ (EXPIRES IN 12 MO. FROM DATE IT WAS SIGNED IF NOT OTHERWISE SPECIFIED).

INITIAL EACH ITEM TO BE RELEASED OR REVIEWED:

_____GENERAL MEDICAL RECORD
_____PROGRESS NOTES
_____DIAGNOSTIC TESTS
_____IMMUNIZATIONS
_____CONSULTATION
_____OTHER _____

IN ADDITION, PLACE YOUR INITIALS BY EACH SPECIFIC ITEM:

_____MENTAL HEALTH _____HIV/AIDS TESTING _____GENETIC COUSELING/TESTING
_____DRUG/ALCOHOL _____ STD

REDISCLOSURE: I UNDERSTAND THAT ONCE THE ABOVE INFORMATION IS DISCLOSED, IT MAY BE REDISCLOSED BY THE RECIPIENT AND THE INFORMATION MAY NOT BE PROTECTED BY FEDERAL PRIVACY LAWS OR REGULATIONS.
CONDITIONING: I UNDERSTAND THAT COMPLETING THIS FORM IS VOLUNTARY.
REVOCATION: I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION ANYTIME. IF I REVOKE THIS AUTHORIZATION, I UNDERSTAND THAT I MUST DO SO IN WRITING. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO MY INSURANCE COMPANY.

_____ _____
PATIENT/ PARENT OR LEGAL GUARDIAN DATE

_____ _____
PRINTED NAME RELATION TO PATIENT

_____ _____
WITNESS DATE

NOTE TO MEDICAL RECORDS OFFICE: IF FAXING MORE THAN 10 PAGES PER PATIENT, PLEASE CALL FIRST