AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's Name___________________________________SS#______________________________

Patient's Date of Birth _____________ Parent or Guardian Name __________________________

I hereby authorize ____

Phone # _____________________________Fax # _______________________________________

To release any and all information to ABC PEDIATRICS OF ST LUCIE pertaining to the aforementioned patient, including diagnosis and medical records, examination(s) rendered to the patient named above, to include but not limited to any federal and state protected documents under Florida Statute 394.459 (9) Psychiatric information, Florida Statute 396.112 Drug and Alcohol Abuse Information and Florida Statute 381.609 (2) human Immunodeficiency Virus Test results (Aids and related conditions).

All Medical Information __________________Laboratory Report (s) ________________________

Immunization Records ONLY ___________ Newborn Screen ONLY ______________________

Discharge Summary ONLY for Hospitalization date's of _____________ to ______________

OTHER ____

I understand and direct this authorization to remain in effect for six (6) months or until I revoke it in writing. I hereby release to your office or facility and its employees from any and all liability that may arise from the release of this information, as I have directed.

RELEASE TO **ABC PEDIATRICS OF ST LUCIE** **FAX: 772-344-1786**

1100 SW ST LUCIE WEST BLVD
SUITE # 105 PSL, FL 34986
PH: 772-344-1775

SIGNATURE OF PARENT/GUARDIAN____

DATE____