



Gainesville Pediatric Associates

**AUTHORIZATION FOR RELEASE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Release Records to:**

Parent/Physician/ Facility: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Request Records from:**

Physician/ Facility: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

**Establishing with:**

Dr. Wyatt  Dr. Grooms  Dr. Boon  Chris Schreier  Tanya Banks

**Please release the following information:**

All Records  Shot Records  Other (Specify)

This authorization will expire one year from today's date unless otherwise stated.

There will be a charge for the release of medical records, \$1 per page for the first 5 pages; \$0.25 for each additional page.

I understand that the information in my child's health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_