

FLORIDA PEDIATRIC ASSOCIATES

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

I hereby authorize _____
to release medical, psychological, psychiatric, developmental-alcohol and/or drug abuse, human immunodeficiency virus (HIV)
testing and treatment, AIDS related information, and genetic information as it concerns the above referenced patient as
follows:

For the dates of service from: _____ to: _____

RELEASE TO:

Florida Pediatric Associates, LLC
Tampa Bay Allergy
Attn: Medical Records
3251 McMullen Booth Rd, Ste 300
Clearwater, FL 33761

Fax: 727-725-2577

WHAT TO RELEASE:

☐ All Medical Records/Information ☐ Abstract ☐ History & Physical ☐ Outpatient Record ☐ Diagnostic Test/Results
☐ Discharge Summary ☐ Other: _____

PURPOSE (i.e., my medical care, legal purposes, etc.): _____

FORMAT: I request that my medical information be provided as follows:

☐ On paper ☐ Discuss my medical information only ☐ Other: _____

If requesting an unencrypted format, by signing below I acknowledge that I understand the inherent risks involved with sending
and receiving information in an unencrypted, unsecured, format (such as regular email or unencrypted disc). Such risks include
misdirected messages, email intrusion, interception, or views by unauthorized parties.

EXPIRATION:

This authorization will be valid for one year from the date signed, unless otherwise specified here: _____
Expiration Date

This authorization is voluntary. Refusal to sign this authorization will not lead to an impact on my treatment, or refusal by my provider to
provide treatment services to me/my child. I understand that my provider may charge a reasonable fee, as allowed by law, for a copy of
my/my child's health information. I may revoke this authorization by submitting my request in writing to provider who received this
authorization but understand that such revocation will not apply to actions already taken by my health care provider prior to my revocation.
I also understand that once my/my child's medical information is disclosed based on this authorization, it may be further used or disclosed
and will no longer be protected by state or federal privacy laws.

Signed: _____
(Patient or Representative)

Date: _____

(Relationship to patient if not patient)

Telephone Number: _____

*For individuals/representatives acting on behalf of the patient, you must indicate your relationship to the
patient above and attach proof of your authority to act on the patient's behalf (other than natural parents).*