ISLAND COAST PEDIATRICS

Authorization for Release of Medical Information

I hereby authorize Island Coast Pediatrics to transfer, release or obtain information on:

(Patient's Full Name)	(Patient's DOB)	(Parent/Legal Guardian Primary Phone #)

Please check if records are coming to or from Island Coast Pediatrics

☐ **To:** **Island Coast Pediatrics**
☐ **From**: 12550 Professional Park Dr. Suite 11
Fort Myers, FL 33913
Phone: (239) 768-2111
Fax: (239) 482-4404

*****We prefer records to be faxed*****

_____
Parent or Physician Name

_____
Street Address, City, State, Zip Code

_____
Phone and Fax Number

☐ I will **Pick up** records at the following office: ☐Fort Myers ☐Estero ☐Cape Coral
☐ **Fax** records to: _____
☐ **Mail** records to Address indicated above (see fee policy below)

Please check specified information requested: ☐ All Records ☐ School/Daycare Forms
☐ Immunizations ☐ Other (specify) _____

Reason for Release: ☐ Transfer of care due to: _____ ☐ Specialist ☐ Personal Use

I understand that my records may contain but are not limited to history, diagnosis, and/or treatment of HIV (AIDs Virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, Psychiatric/Psychological conditions or genetic counseling. I give my specific authorizations for these records to be released.

___ ***Yes, I consent to the release of this information*** (initial)
___ ***No, I do not consent to the release of this information*** (initial)

Island Coast Pediatrics takes necessary steps to protect our patient's private health information. This authorization is valid for 90 days from the date of request below. I understand I may cancel this request with written notification; however, this would not affect information released prior to my cancellation request. The first request for medical records is provided at no charge; however, a fee may apply to records being mailed. I understand I am financially responsible for additional copies at the cost of $1.00 per page for the first 25 pages and .25 cents for each additional page.

I understand the requirements of this authorization release and voluntarily consent to the release of my record or my child's record to where I have indicated above. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected by Federal Privacy Rules. Medical Records may take 7-10 business days from the date of receipt to process your request. Please contact us if you have any questions regarding this authorization release form.

Print Parent or Guardian Name of Minor	**Signature** of Parent or Guardian of Minor *(Or Signature of Patient if 18 yrs or older)*	**Date** of Request

****

Office Use Only: _____ _____
Employee who received Auth Release *Employee who faxed Auth Release to Physician or Facility*

1.22.15