



# Children's Medical Center

Board Certified Pediatricians

## Medical Record Release Authorization

Date: \_\_\_\_\_

I hereby authorize and request: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

|  |  |
|--|--|
| <input type="checkbox"/> Office Visit (Dates/Doctor) _____ | <input type="checkbox"/> Lab Reports (Date) _____  |
| <input type="checkbox"/> Procedure (Date) _____            | <input type="checkbox"/> Xray Reports (Date) _____ |
| <input type="checkbox"/> Immunization Record               | <input type="checkbox"/> Billing Information       |

These records are to be forwarded to: \_\_\_\_\_

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Patient(s) Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Patient(s) Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Patient(s) Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Patient(s) Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Any other information to further identify the patient(s): \_\_\_\_\_

Please state the reason for requesting medical records: \_\_\_\_\_  
(ex. changing physicians, moving, own use, insurance purposes, etc.)

Signed: \_\_\_\_\_  
(Relationship to the patient)

Print Name: \_\_\_\_\_

**Please note that there will be a \$1.00 per page charge on medical records released to parents that are picking them up for their own use (please see below re: this information).** This form must be received within 6 months of the date that it is signed, and it is valid for 90 days after receipt. It may be revoked at any time upon written request to NPCMC, unless the requested information has already been disclosed. A fax machine may be used to transmit this information, and faxing may increase the risk of accidental disclosure of this information to unauthorized parties. Information released may include but is not limited to alcohol or drug abuse, HIV, mental health, or communicable disease information, which may be part of your health record. Your medical record may contain records from other health care providers. Please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by the HIPAA Rules. If I refuse to sign the authorization, my information will not be released except as required by law. I agree to hold NPCMC harmless and release them from any liability for any claims or actions, which may occur as a result of the release of the information.

\*State of Florida R.7/89 Department of Professional Regulation 21M-26.003: Cost of Reproducing Medical Records

(5) Any person licensed pursuant to Chapter 458, F.S. required to release copies of patient medical records may condition such release upon payment by the requesting party of the reasonable cost of reproducing the records.

(6) Reasonable costs of reproducing copies written or typed documents or reports shall not be more than the following: (e) For the first 25 pages, the cost shall be \$1.00 per page.

(f) For each page in excess of 25 pages, the cost shall be 25 cents.