Premier Care Pediatrics
16637 Fishhawk Blvd. Suite 101 • Lithia, FL 33547-3800
Phone (813) 657-7337 • Fax (813) 661-4702
http://www.premiercarepeds.com

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Name: _____ DOB: _____ Phone #: _____

Street Address: _____ City, State, Zip: _____

PLEASE **OBTAIN** INFORMATION **FROM**:

_____
Name of Provider/Clinic/Organization

_____
Street Address

_____
City, State, Zip Code

_____ _____
Phone: Fax:

PLEASE **SEND** INFORMATION **TO**:

Premier Care Pediatrics
Name of Provider/Clinic/Organization

16637 Fishhawk Blvd. Suite 101
Street Address

Lithia, FL 33547
City, State, Zip Code

(813) 657-7337 **(813) 661-4702**
Phone: Fax:

I AUTHORIZE the following information to be disclosed: (Please mark all that apply)

- ☒ Complete Health Records
- ☐ Immunization Record
- ☐ Growth Charts
- ☐ Well Child Visits
- ☐ Progress Notes
- ☐ Consult Notes
- ☐ Medication History
- ☐ Date(s)_____
- ☐ Other _____

I understand that the information in my 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.

EXPIRATION of this Authorization:
I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

ADDITIONAL PATIENT INFORMATION:
If I fail to specify an expiration date, event or condition, this authorization will expire in ninety days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

_____ _____
Signature of Patient or Guardian Date Signature of Witness Date

_____
Name of Patient or Guardian Relationship

☐ Pick-Up Records ☐ Mail Records ☒ FAX Records