

**Island Pediatrics**  
**4611 Highway 17, Suite 2**  
**Fleming Island, FL 32003**  
**Ph: (904) 264-4333 Fax (904)264-4301**



**Authorization for Release of Protected Health Information**

Patient's Name \_\_\_\_\_ DOB \_\_\_\_\_

\_\_\_\_\_ DOB \_\_\_\_\_

Parent/Gdn Name \_\_\_\_\_ Phone \_\_\_\_\_

**Copies of patient's medical record to be released:**

**FROM:** \_\_\_\_\_ **TO:** \_\_\_\_\_

\_\_\_\_\_

For the specific purposes I have checked below:

- Changing primary care physician and discontinuing care at this office
- Leaving town and transferring records to my new physician
- Personal reasons
- Other: \_\_\_\_\_

**ALL PATIENT INFORMATION IS CONFIDENTIAL AND PRIVILEGED**

The confidentiality of patient records is protected by Federal Law. Federal Law prohibits the recipient from making any further disclosure. A general authorization for the release of medical information is NOT sufficient for this purpose.

I agree to hold Island Pediatrics harmless from any and all costs, liability and damages of any nature whatsoever including reasonable attorney's fees, resulting directly or indirectly from the release of my medical records pursuant to this content.

AS PART OF THE MEDICAL RECORD, THE FOLLOWING INFORMATION WILL BE RELEASED UNLESS STRICKEN:

- SEXUAL ABUSE INFORMATION
- DRUG ABUSE INFORMATION
- CHILD ABUSE AND NEGLECT INFORMATION
- PSYCHIATRIC INFORMATION
- AIDS / HIV INFORMATION

I acknowledge that I have read this authorization and fully understand its contents.

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

*(Patient, Parent or Guardian)*

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

**For office use:** Information was MAILED / PICKED UP by \_\_\_\_\_ on \_\_\_\_\_