THE KID'S DOCTOR

CONSENT FOR RELEASE OF MEDICAL INFORMATION AND/OR X-RAY FILMS

Patient Name: _____ SS #: _____

D.O.B: _____ Phone #: _____

I authorize _____

Name of Facility / Person maintaining medical information

to release copies of my medical records to: _____

_____

Name of Facility or Person and Address

A. I authorize release of information for:
- _____ medical care (physicians, etc..)
- _____ personal use
- _____ other: _____
  employer, Insurance, attorney, etc.

B. I am transferring from medical office _____

to _____

C. I authorize release of my (refer to section d, if applicable)
- _____ entire medical record

-or-
- _____ medical records for the specific treatment dates from _____
- _____ to_____.

D. I authorize release of the following portions of my medical record:
(write your initials beside each area to be included in release).
- _____ Diagnosis &/or treatment for mental health/rehabilitation (FL Statute 455.241)
- _____ Diagnosis &/or treatment for alcohol &/or substance abuse (FL Statute 396.112) and C.F.R. 42 part 2)
- _____ HIV antibody test and/or AIDS diagnosis &/or treatment (FL Statute 381.004)
- _____ Genetic Testing

E. I authorize release of x-ray films, #_____.

to _____

I understand that I have the right to refuse or to withdraw this authorization (withdrawal must be in writing). I also understand that this authorization will remain in effect for ninety (90) days unless I specify an earlier date here:_____

I have carefully read tne information above and the attachment that explains that my medical record may contain information that is considered "super confidential". I have had the opportunity to ask questions and I request that my medical records be released as designated.

Date: _____ _____

Witness

_____ _____

Signature of Patient or Representative Relationship to Patient (If Applicable)

Physician's Signature:

10549 North Florida Avenue Suite B • Tampa, Florida 33612
(813) 978-1522 • Fax (813) 971-3330