Authorization for Release of Medical Information

I,_____, parent or legal guardian of:

Patient Name:_____ Date of Birth:_____

Patient Address:_____

Patient Phone number:_____

hereby consent to the disclosure and release of medical records pertaining to (please circle):

Immunization history All records Other (please specify):_____

FROM: Pediatrics by the Sea
Bradley J. Bradford, M.D.
Shani-Kay Chambers, M.D.
Deborah Stemp, M.D.
Michelle Supraski, PA-C
285 SE 5th Avenue
Delray Beach, FL 33483
Ph: 561.272.8991
Fax: 561.272.8985

TO: _____

Phone:_____

Fax:_____

The question of privacy between the physicians at the sending facility and my child(ren) is(are) waived. I fully understand that my child(ren)'s medical record or information maintained in connection with the date(s) of service may contain mental health, alcohol, and drug abuse, Human Immunodeficiency Virus (HIV) test results or Acquired Immunodeficiency Syndrome (AIDS) information. The medical records or information authorized to be disclosed by this release are privileged and confidential and may be disclosed only on my, or another legal guardian's authorization, except as required by law. Only such information believed to be necessary for the purpose expressed shall be released and disclosed. I may inspect and arrange for photocopies of the records that are disclosed. If another legal guardian, or I, refuses to sign this authorization, my child(ren)'s records will not be released.

This authorization is valid for one year from the signed date. I may revoke this authorization at any time (except to the extent that action has already been taken in good faith reliance on this authorization) by submitting a written revocation request to the releasing agency.

I understand that I am responsible for any charges incurred for the copying and production of these records. These include a charge of $1 per page for an amount of pages less than 25 pages, and 25 cents per page for any page over 25 pages. If the chart is in a storage location, I will be charged a $25 fee for retrieval of the chart from storage.

Parent/Guardian Signature_____ Relationship:_____

Printed name:_____ Date:_____

Witness's Signature: _____ Date:_____

FOR OFFICE USE ONLY

ailed/Faxed immunization record by _____ on _____

ailed/Faxed all requested information by _____ on _____