**Dr Q Pediatrics**
**448 S Alafaya Trail Ste 1, Orlando, Fl 32828**
**Phone:407-275-5700 Fax:407-381-5802**

# Authorization to **Release/Obtain** Protected Health Information

Patient Name: _____ Date of Birth: _____
Address: _____ Phone: _____
Person requesting Medical Records: _____ Relation to patient: _____

**Release Medical records to:**
Facility name:

**Obtain Medical Records From:**
Facility name: **448 S Alafaya Trail Ste** 1
Orlando, FL 32828
PH:407-275-5700 FAX:407-381-5802

. I am Requesting Medical Records for Dates: From: _____ to: _____. I authorize the following types of information to be released.

**_X__ Problem List**
**_X__ Medications/Immunizations**
**_X__ Allergies (all of them).**
**_X__ Last labs/diagnostic reports**
**_X__ Growth Chart**

***NO DISCS! *DO NOT SEND COMPLETE RECORDS, UNLESS AUTHORIZED BY OFFICE.**

**If whole chart is sent there would be a fee to review and process billable to caretaker.**

. If there is any part of the record you do not wish released, please indicate here_____
If your records contain any information about substance (drug or alcohol) abuse, HIV, or mental Health, may this information be released? If yes please initial next to each type of information to be released:

**_____Drug and/or alcohol treatment or testing ____HIV _____Mental Health**

Your permission will expire 90 days after you sign this form unless you indicate otherwise. If you would like to extend your permission for longer than 90 days, please tell us when. The date cannot be more than a year from now: _____

Understanding this Authorization:
. This allows the release or obtaining of information that exist in the patient's medical record when the form is signed, as well as information created after the form is signed until expires.
. I may withdraw my permission at any time by providing written notice to the above-named provider releasing the information.
For information being release by Dr Q Pediatrics, see its Notice of Privacy Practices for instructions on how to withdraw (revoke) an authorization. If I withdraw my permission any information that was released cannot be retrieved.
. Information released by Dr Q Pediatrics may be released again by the person or organization that receives it and is no longer protected under federal laws.
. I understands my permission is voluntary and I/my child will receive treatment whether or not I sign this form.
. I understand that there may be cost associated with this request in compliance with State and Federal Laws.
**By signing I understand that I am authorizing Dr Q Pediatrics to release/obtain information as describe above.**

**Signature: _____ Date: _____**