103 Park Place Blvd
Davenport, FL 33837
Phone: 863-421-1855
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Authorization for Release of Protected Health Information

Section A: Must be completed for all authorizations

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient(s) Name:_____ Date of Birth:_____

FROM: **Davenport Pediatrics PA**
103 Park Place Blvd
Davenport FL 33837
Fax: 863-421-2624

TO: Organization to RECEIVE the information:
(provide fax number and/or mailing address)
_____
_____
_____

Specific description of Information {including date(s)}:

(Check one)

_____ All Records (including Mental Health/Sexual Abuse/HIV)
_____ All Records (excluding Mental Health/Sexual Abuse/HIV)
_____ Records Within the Following Date Range: from _____ to _____
_____ Immunization record only
_____ Physical forms only
_____ Last Well Child Visit/Physical/Growth Chart/Immunization Chart
_____ Sexual Abuse Only
_____ HIV only
_____ Mental Health Records (Including ADHD) Only
_____ Other: Please specify_____

Section B: Must be completed for all authorizations

The patient or patient's representative must read the following statements:

1. I understand that this authorization will expire on _____ (or one year from date of signature).
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing; but, if I do, it would not have any effect on any actions they took before they received the revocation.
3. If a health care provider is receiving these records, the information will be used for continuity of care purposes only.
4. I understand that I may have a copy of this form at any time when requested.
5. I understand that my health care and payment for my health care will not be affected by signing this form.

X_____ _____ _____
Signature of patient or patient's representative Phone Number Date
(Form MUST be completed before signing)

Printed name of patient's representative:_____

Relationship to patient:___________________________________