8734 Lee Vista Blvd. Suite 400 Orlando, FL 32829
Tel:(407) 910-2340 Fax: (407) 237-0944

AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS

Patient Name: _____ **Date of Birth:** _____
Current Address: _____
Current Phone Number: _____

Please check and fill out one of the following:

_____ By signing below, I authorize Little House Pediatrics to **OBTAIN** protected health information about the patient named above from:
Name of Physician/Organization:_____
Address: _____
Phone Number: _____ Fax Number: _____

Please send us the following:
____ Copy of records from the past 2 years
____ Birth records and Infant Screen (PKU)
____ Problem list/medical summary
____ Immunization records
____ Growth Charts
____ Labs & X Rays reports

_____ By signing below, I authorize Little House Pediatrics to **RELEASE** protected health information about the patient named Above to:
Name of Physician/Organization:_____
Address: _____
Phone Number: _____ Fax Number: _____

The entire medical record will be released unless otherwise specified below.
____ Records from _____ to _____
____ Labs from _____ to _____
____ Other
____ Immunizations only
____ Imaging from _____ to _____

This release and all authority to disclose information shall expire on _____ or one year from the date of the signature below.

I understand that these records may include information relating to psychological, psychiatric, sexually transmitted diseases, AIDS, HIV, alcohol or drug related problems. I recognize that the health information disclosed may contain information that is privileged and protected by law and I specifically consent to the disclosure of such information. All records obtained will be used solely for professional purposes, will remain confidential and may not be disclosed to third parties. I understand the following:

- I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
- The information released in response to this authorization may be re-disclosed by the recipient.
- My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

In consideration of this consent, I hereby release the above parties from any and all liability arising there from.

_____ _____
Signature of Patient/Parent/Legal Guardian **Print Name of Patient/Parent/ Legal Guardian**

Date: _____