INTERLACHEN PEDIATRICS

Consent for Release of Confidential Medical Records

Patient Name:_____ Date of Birth:_____

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Purpose/ Need for Information:

☐ Continuing Medical Care (Referral to Specialist) ☐ Insurance ☐ Legal Review/Action ☐ Personal Use

☐ Changing Physicians ☐ Moving ☐ Over 18 ☐ Dissatisfied with Care

☐ Other (Please Specify) _____

Specific Documentation Requested:

☐ Our Visit Notes ☐ Immunizations ☐ Laboratory Reports ☐ Radiology Reports

☐ Consultations ☐ Behavioral/Psychiatric (please initial) _____

☐ Other (Please Specify) _____

This information, including diagnosis and records of any evaluation, examination and/or treatment rendered to the above named during the period: _____

I request and authorize Interlachen Pediatrics to RELEASE / OBTAIN (please circle one) medical information, which may include patient psychiatric counseling and treatment information and/or other sensitive information pursuant to Florida Statutes 394.459 (9), 397.053,396.112, 381.609 and 397.501 (3) for the patient(s) named above TO / FROM (please circle one):

Name: _____

Address: _____

City: _____ State:_____ Zip:_____

Phone:_____ Fax:_____

I understand this consent will automatically expire in ninety (90) days from the date of my signature, or when the request has been processed, whichever comes sooner. I also understand it is subject to revocation in writing at any time before the expiration date except to the extent that action has already been taken.

_____ _____

Signature of Patient/ Legal Representative Date

_____ _____

Printed Name Relationship

_____

E-mail Address* (Please provide so we may notify you when your records have been processed)

Please allow 7-10 business days for records to be processed. Thank you!

Interlachen Pediatrics
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www.intpeds.com