2115 S.E Lennard Rd, Port St. Lucie, FL -34952 Phone: 772-335-1812 Fax: 772-335-1825

Authorization For Release of Medical Records
HIPPA Form-B

Patient's Name: _____ DOB: _____

Name of Parent / Guardian: _____

This authorization permits: (previous doctor's name and/or Practice name**)**

_____
Previous Doctor's name and/or Practice name

_____
Street Address

_____
City, State, Zip

_____- _____-_____ _____- _____-_____
Phone # Fax #

To use or disclose to:

Tender Care Pediatrics
New Provider, Specialist, or person receiving copy

2115 SE Lennard Road
Street Address

Port St. Lucie, Florida 34952
City, State, Zip

772-335- 1812 772-335-1825
Phone # Fax #

To release any and all information to Dr. Anitha Jagadish, M.D. / Dr. Arturo Gamez, M.D., pertaining to the aforementioned patient, including diagnosis' and medical records of any/and all treatment(s) and/or examination(s) rendered to the patient named above, to include but not limited to any federal and state protected documents under Florida Statute 394.459(9) Psychiatric Records; Florida Statute 381.609(2) Human Immunodeficiency Virus test results (aids and related conditions). I am aware that the information released pursuant to this authorization is subject to re-disclosure by the recipient and may no longer be protected by the HIPPA rule.

Information to be Released/Copied

( ) All pertinent Medical records including Immunizations and Lab Tests

( ) Immunization Records, Last Physical Exam, Medication List*

( ) Other: _____

I understand that this authorization will expire in six months. I further understand that I may revoke this authorization at any time during this period by notifying the providing organization in writing.

For Patient or Guardian Inspection / Copy Requests: ( ) Check here

I understand and agree that I am financially responsible for the following fees associated with my request: copying charges including the cost of supplies and labor and postage related to the production of my information. I understand that the charges for this service are $1.00 per page for the first 25 pages, then $.25 per page thereafter.

Parent/Guardian's Signature: _____ Date: _____

Relationship to Patient: _____