



12086 Fort Caroline Road, Suite 401
Jacksonville, FL 32225
P: 904-456-9240

Authorization for Release of Medical Information

Patient Name: _____ DOB: ____/____/____

I, _____
(parent's name) hereby authorize the release of medical
information

TO:

Clinic: Ellis Pediatrics, PLLC

Address: 12086 Fort Caroline Road, Suite 401
Jacksonville, FL 32225

Telephone: Phone: 904-456-9240 Fax :833-464-4948

FROM:

Doctor/Clinic/Hospital: _____

Address: _____

Telephone: _____ Fax : _____

Please release the following:

☐ **All health information (including growth charts and vaccination records)**

☐ History/Physical Exam ☐ Discharge Summary ☐ Diagnostic Test Reports ☐ Lab Results

☐ Progress Notes ☐ Consultation Reports ☐ Radiology/Images ☐ Pathology Reports

☐ Other (specify): _____

I consent to the release of information related to HIV/AIDS or infection with any other communicable diseases and information related to behavioral or mental health services and treatment for alcohol and drug abuse, with the rest of the medical records

☐ Yes, I consent to the release of this information.
☐ No, I do not consent to the release of this information.

Purpose of disclosure:

☐ Treatment/ Continuing medical care

I understand that I may revoke this authorization in writing at any time. Otherwise, this authorization shall remain valid until such time as it is revoked in writing.

Signature of Parent or Legal Guardian: _____ Date: ____/____/____

Print Name: _____ Relationship to Patient: _____