OPTIMAL CARE PEDIATRICS
150 SW Chamber Court, Ste 101, Port St. Lucie, FL 34986 | optimalcarepeds.com | (772) 301-0123

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN THIS FORM

I, _____hereby voluntarily authorize the disclosure of information from my child(ren)'s health record.

From:

Facility/Provider name: _____

Facility Address (City, State, Zip)**:** _____

Phone#:_____ Fax#:_____ Email address: _____

Patient Information:

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Address (City, State, Zip): _____

Information Requested:

All Medical records Labs/radiological imaging only Hospital reports

Other/Please specify_____

Purpose of Release: _____

The Information Is To Be Released To:
Optimal Care Pediatrics
150 SW Chamber Ct, Ste 101
Port St. Lucie, FL
34986
Phone#: 772-301-0123
Fax#: 772-301-0124

_____ _____
Patient's Signature or Patient's Representative Date

_____ _____
Printed Name of Patient's Representative Relationship to Patient

This information is to be released for the purpose stated above and may not be used by recipient for any other purpose.

PLEASE MAKE A COPY OF THIS RELEASE FOR YOUR RECORDS

HIPAA Authorization For Release of Medical Records