



### Authorization for Release of Medical Information

I hereby authorize Island Coast Pediatrics to release information on:

\_\_\_\_\_  
(Patient's Full Name) (Patient's DOB) (Parent/Legal Guardian Primary Phone #)

**From: Island Coast Pediatrics**  
632 Del Prado Blvd. N. Ste. 301  
Cape Coral, FL 33909  
Phone: (239) 768-2111  
Fax: (239) 482-4404  
**\*\*\*We prefer to fax records\*\*\***

**To: \_\_\_\_\_**  
**Parent or Physician Name**  
\_\_\_\_\_  
**Street Address, City, State, Zip Code**  
\_\_\_\_\_  
**Phone and Fax Number**

- I will **Pick up** records at the following office: Fort Myers Estero Cape Coral
- Fax** records to: \_\_\_\_\_
- Mail** records to Address indicated above (see fee policy below)
- Electronically** via: USB Disk Email: \_\_\_\_\_ (I understand email is not secure)

<p><b>Please check specified information requested:</b> <input type="checkbox"/> All Records <input type="checkbox"/> School/Daycare Forms <input type="checkbox"/> Immunizations <input type="checkbox"/> Other (specify) _____</p> <p><b>Reason for Release:</b> <input type="checkbox"/> Transfer of care due to: _____ <input type="checkbox"/> Specialist <input type="checkbox"/> Personal Use</p>
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I understand that my records may contain but are not limited to history, diagnosis, and/or treatment of HIV (AIDs Virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, Psychiatric/Psychological conditions or genetic counseling. I give my specific authorizations for these records to be released.

\_\_\_\_\_  
(initial) **Yes, I consent to the release of this information**      \_\_\_\_\_  
(initial) **No, I do not consent to the release of this information**

Island Coast Pediatrics takes necessary steps to protect our patient's private health information. This authorization is valid for 90 days from the date of request below. I understand I may cancel this request with written notification; however, this would not affect information released prior to my cancellation request. The first request for medical records is provided at no charge; however, a fee may apply to records being mailed. I understand I am financially responsible for additional copies at the cost of \$1.00 per page for the first 25 pages and \$0.25 for each additional page.

I understand the requirements of this authorization release and voluntarily consent to the release of my record or my child's record to where I have indicated above. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected by Federal Privacy Rules. Medical Records may take 7-10 business days from the date of receipt to process your request. Please contact us if you have any questions regarding this authorization release form.

\_\_\_\_\_  
**Print** Parent or Guardian Name of Minor      \_\_\_\_\_  
**Signature** of Parent or Guardian of Minor  
(Or Signature of Patient if 18 yrs or older)      \_\_\_\_\_  
**Date** of Request

\*\*\*\*\*

**Office Use Only:** \_\_\_\_\_  
Employee who received Auth Release      Employee who faxed Auth Release to Physician or Facility