



## Medical Record Release Authorization

I hereby authorize and request: \_\_\_\_\_  
(Previous Doctor's name)

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

<input type="checkbox"/> Office visit (Dates/Doctors) _____	<input type="checkbox"/> Lab Reports (Date) _____
<input type="checkbox"/> Procedure (Dates) _____	<input type="checkbox"/> X-ray Reports (Date) _____
<input type="checkbox"/> Immunization Record	<input type="checkbox"/> Billing Information

Forward records to: **East Lake Pediatrics • 4150 Woodlands Parkway, Suite B • Palm Harbor, FL 34685**

Patient(s) Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient(s) Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Patient(s) Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Any other information to further identify the patient(s): \_\_\_\_\_

Please state the reason for requesting medical records: \_\_\_\_\_  
(Ex: changing physicians, moving, own use, insurance purpose, etc.)

**Please note that there will be a \$1.00 per page charge on medical records released to parents that are picking them up for their own use.** This form must be received within 6 months of the date that it is signed, and it is valid for 90 days after receipt. It may be revoked at any time upon written request to ELP, unless the requested information has already been disclosed. A fax machine may be used to transmit this information, and faxing may increase the risk of accidental disclosure of this information to unauthorized parties. Information released may include but is not limited to alcohol or drug abuse, HIV, mental health, or communicable disease information, which may be part of your health record. Your medical record may contain records from other health care providers. Please be aware that once we disclose this information per your instructions the information is subject to re-disclosure and may no longer be protected by the HIPAA Rules. If I refuse to sign the authorization, my information will not be released except as required by law. I agree to hold ELP harmless and release them from any liability for any claims or actions, which may occur as a result of the release of the information.

Signed: \_\_\_\_\_  
(Relationship to the patient)

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_