Celebration Pediatrics

1530 Celebration Boulevard, Suite 301, Celebration, Florida 34747
Phone (407) 566-9700 Fax (877) 534-5105

AUTHORIZATION TO REQUEST OR RELEASE HEALTH INFORMATION

1. I, ____ the parent or guardian of:

   Name: ___________________________________ DOB: ____________
   Name: ___________________________________ DOB: ____________
   Name: ___________________________________ DOB: ____________
   Name: ___________________________________ DOB: ____________

Hereby authorize Celebration Pediatrics Associates, PA to:

☐ **Request records from**:

Physician and/or Practice Name ____

Address: ____

Phone: _______________________ Fax: ______________________

☐ **Release records to**:

Physician and/or Practice Name____

Address: ____

Phone: _______________________ Fax: _______________________

2. The following type of medical information: (list dates and test if specifics needed)
   - Lab results: _____________________________
   - Image results: ___________________________
   - Immunizations: ___________________________
   - Physicals: ________________________________
   - Entire Medical Record: _____________________
3. By indicating “Entire Record” all medical information, information regarding any sexually transmitted disease, psychiatric treatment, drug and/or alcohol abuse, HIV testing, ARC and/or AIDS information in my records will be released. If you prefer certain medical information not be released, please contact the appropriate office staff.
4. This information for which I am authorizing disclosure will be used for the following purpose:
   ☐ Referral ☐ Relocation ☐ Transfer of care ☐ Insurance ☐ Legal review
   ☐ Other (Please Specify) ____
5. This authorization will expire on: ____
6. If I fail to specify a date, this authorization will expire in 6 months from the date it was signed.
7. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization in writing, the revocation will not apply to information that has already been released.
8. I understand that the information has been disclosed, the recipient may re-disclose it and federal privacy laws may not protect the information

_______________________________ _______________________________
Signature of Authorized Representative Date

_______________________________ _______________________________
Witness Phone number of Authorized Representative

Fee for copying chart is $1.00 per page up to 25 pages, .50 cents per page thereafter. Authorization must be signed and payment before chart will be copied. Please allow 7-10 working days to copy chart.