AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PATIENT INFORMATION

To:_____

Address:_____

Telephone Number:_____ Fax Number:_____

Patients Name:_____ DOB:_____

SSN:_____ Telephone Number:_____

- ☐ Full Medical Record
- ☐ Immunization Record
- ☐ Physical Exams and Growth Charts
- ☐ Specified Items Requested_____

Please mail or fax requested information to:
Katz Pediatrics
1050 SE Monterey Road, Suite 301
Stuart, FL 34994
Phone: 772-678-7474
Fax: 877-227-8185

I understand that such medical records may contain information regarding psychological, drug, and / or alcohol conditions, and / or diagnosis, treatment and care of sexually transmitted diseases, including but not limited to HIV testing and results. I hereby authorize the release of such medical records pursuant to this authorization for release of medical records, and waiver confidentiality provisions pertaining to this release
I have read Katz Pediatrics' Notice of Privacy. I hereby release Katz Pediatrics and its employees from any and all liability that may arise from the release of information as I have directed.

Pursuant to Florida Law and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rules, the record may be given only to the person designated, and it may be used only for the purpose listed on this form. Charges are in compliance with the Florida law. I understand that once information is disclosed to the recipient above, it may be redisclosed to individuals not subject to HIPAA and may no longer be protected by HIPAA. I understand that signing this authorization is voluntary and will not affect my receipt of treatment. I understand that I may revoke this authorization at any time, in writing to an authorized employee of Katz Pediatrics to the address listed above provided that the information has not been yet released. This authorization expires in (1) year unless another date is written here:_____

_____ _____
Signature of Patient or Guarantor Date