PEDIATRIC CARE CENTER
OPEN 24 HOURS, 7 DAYS A WEEK

JACKSONVILLE (904) 519-6555
8117 Point Meadows Drive • Jacksonville, FL 32256
JACKSONVILLE BEACH (904) 249-3373
274 Third Avenue South • Jacksonville Beach, FL 32250
24hourkidcare.com

REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT TO COMPLETE:

I hereby authorize,

Previous Physician Name _____ **City/State**:_____

Physician Phone Number _____ **Fax Number** _____

to release complete medical record copies for the following:

_____

Child's Name Date of Birth

_____

Child's Name Date of Birth

_____

Child's Name Date of Birth

Advance notice must be given to allow our staff ample time to get these records copied. Record must be sent to another physician or the parent/guardian must pick them up. This authorization will expire one year from today's date, unless otherwise specified.

I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS or HIV. It may also include information about behavior or mental health services and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time except to the extent action has been taken prior to revocation. I understand that if I revoke this authorization, I must do so in writing to the address of the releasing institution. I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be re-disclosed by the person or entity that received the information in accordance with Florida law. I also understand I may be charged for copies of this information in accordance with Florida law. I understand the matters discussed on this form. I release the provider, and al persons associated with this company from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein. I understand I do not have to sign this authorization in order to obtain healthcare treatment.

Parent/Guardian Signature _____ Today's Date _____

Parent/Guardian Printed Name _____ Relationship to Patient _____

Parent/Guardian Phone Number _____

PLEASE RELEASE COMPLETE RECORDS TO THE FOLLOWING:

Pediatric Care Center – Point Meadows
8117 Point Meadows Way
Jacksonville, FL 32256
Phone: (904) 904-519-6555 Fax: (904) 519-6550

OFFICE USE ONLY:

First Fax Attempt: _____ Second Fax Attempt: _____

NOTES / MESSAGES

Date	Message / Pending Action	EMPLOYEE INITIALS