



Weiss Pediatric Care

2201 Cantu Court, #117 Sarasota, FL 34232 | P: 941-552-8341 | F: 941-487-8025 | weisspediatriccare.com

AUTHORIZATION TO RELEASE PATIENT MEDICAL INFORMATION

INFORMATION ABOUT THE PATIENT:

Patient Name: _____
Last First Middle

Birthdate: ____/____/____

Address: _____

Phone: _____

RECORDS TO BE RELEASED FROM:

Name of Health Care Provider

Street Address

City, State, Zip Code

RECORDS TO BE RELEASED TO:

Weiss Pediatric Care

2201 Cantu Court, Suite 117

Sarasota, Florida 34232

INFORMATION TO BE RELEASED:

I hereby authorize the release all of my medical records including information pertaining to (please check below):

_____ Sexually transmitted disease

_____ Testing or treatment of HIV/AIDS

_____ Treatment for alcohol or substance abuse

_____ Mental health treatment, psychological services, social services including communications made to a social worker or psychologist

For the following dates: _____

PURPOSE FOR NEED OF DISCLOSURE: (check one)

____ Further Medical Care ____ Insurance/Eligibility ____ Other (Specify): _____

I understand I must be provided with a signed copy of this authorization. I understand written notification is necessary to cancel this authorization and I may obtain information on how to withdraw my authorization by contacting the office of the above noted healthcare provider. I understand that Weiss Pediatric Care will not be able to release records to someone else without a signed authorization. If I decide not to sign this form, Weiss Pediatric Care will not refuse to continue treatment. By signing this authorization, I do expressly and voluntarily consent to the disclosure of the information checked above to the person/doctor/agency named above. I understand that if the person(s) and/or organization(s) listed above are not mandated by the federal privacy standards, the health information disclosed as a result of this authorization may be redisclosed without obtaining my authorization. I understand that I may be charged a fee for coping medical records.

Name (please print) of Parent/Guardian/Patient (over 18)

Relationship to Patient

Signature of Parent/Guardian/Patient (over 18)

Date

EXPIRATION DATE: This authorization is good until the following date(s) _____ or for six months from the date signed.