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: _____ Birthdate: _____/_____/_____
Last First Middle

Address: _____ Phone: _____

RECORDS TO BE RELEASED FROM:

_____
Name of Health Care Provider

_____
FAX #

_____
Street Address

_____
City, State, Zip Code

RECORDS TO BE RELEASED TO:

Weiss Pediatric Care

941-487-8025
FAX #

2201 Cantu Court, Suite 117
Street Address

Sarasota, Florida 34232
City, State, Zip Code

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.

Rev: 08/18/2017