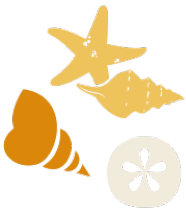

Beachside Pediatrics of Naples

2940 Immokalee Road Suite 2
Naples, FL 34110
Phone (239)- 598-5750
Fax (239) 593-1989

Release of Medical Records TO Beachside Pediatrics of Naples

Patient Information

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Patient Name: _____ DOB: _____

Release Records FROM (doctor, facility, or individual): _____

Address: _____

City / State / Zip: _____ Phone: _____ Fax: _____

Please identify the information to use, release, obtain or disclose:

☐ Please release entire record

OR

☐ Please release ***only*** the following information (check appropriate boxes)

- ☐ Immunization Records
- ☐ Labs Results (please list dates or types of lab tests) _____
- ☐ Radiology (please list dates or type of exam) _____
- ☐ Other (please specify) _____

Authorization *(initial each item below)*

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

_____ I understand once the information below is released, it may be re-disclosed by the recipient and the information may no be protected by federal privacy laws or regulations.

_____ I understand I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to the authorization. I understand the revocation will apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand this authorization will expire twelve (12) months from the date on which it was signed.

_____

Name (print) **Signature** **Date**

Relationship to Patient: ☐ Self (over the age of 18) ☐ Parent ☐ Legal Guardian