Ancient City Pediatrics

1301 Plantation Island Drive, Suite 404
St. Augustine, FL 32080
Phone: (904) 461-1560 Fax: (904) 461-4304

Authorization for Release of Medical Records

Patient Name: _____ Date of Birth: _____
Address: _____
City/State/Zip: _____Phone#:_____

( ) I authorize Ancient City Pediatrics to release my medical information to:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____ _____
Phone# Fax #

OR ( ) I authorize Ancient City Pediatrics to obtain my medical information from:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____ _____
Phone# Fax#

IF THE NUMBER OF PAGES BEING RELEASED TO OUR OFFICE IS MORE THAN 10 PAGES, PLEASE MAIL TO THE ADDRESS ABOVE. **PLEASE DO NOT FAX!!**

Purpose for this request: (check one)
( ) Continuation of Care ( ) Attorney/Legal ( ) Insurance ( ) Other: _____

Specific documents to be Released:
( ) All Documents ( ) AIDS/HIV ( ) Immunizations ( ) Psychiatric
( ) Drug/Alcohol ( ) Progress Notes ( ) Other: _____

Expiration (If left blank, expires one year from date below):
This authorization expires _____. This authorization applies to the records of the treatment received on or prior to the date of this authorization.

I understand that:

- Authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment, payment or eligibility for benefits.
- The information in my/my child's health record may contain information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.
- There may be a charge for copies of my/my child's medical record.
- I may cancel this authorization at any time by submitting a written request to the address above.

Signature of Patient/Parent/Legal Guardian _____Date_____

Printed Name_____ Relationship_____