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Pediatric Orthopedics of Southwest Florida

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Medical Records

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Authorization to **RELEASE** Medical Information

Patient Name: _____ MR #: _____

Date of Birth: _____ Sex: M ☐ F ☐

Prohibition on Re-Disclosure:
This information is being disclosed from records whose confidentiality is protected by State and Federal laws. Regulations prohibit the making of any further disclosure of the information.

I, the undersigned, do hereby authorize and request Pediatric Orthopedics of Southwest Florida to release copies of the above named patient's records TO:

Parent: _____

Physician or Medical Center: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

To include any information related to drug and alcohol use / abuse, psychiatric evaluations / treatment, and / or HIV information, unless this statement is deleted and initialed by authorizing party. The purpose for which this information is being requested in Continuity of Care by the Pediatric Orthopedics of Southwest Florida physicians. I understand this information is revocable by me in writing at any time. This authorization will expire in ninety (90) days from the date of the signature.

Signed: _____ SIGN HERE Relationship to Patient: _____

Witness: _____ WITNESS Date: _____