AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ (Parent/Legal guardian) authorize ALTAMONTE PEDIATRIC ASSOCIATES to obtain / release medical information in the record of my child.

Patient Name_____ **Date of Birth**_____

Patient Name_____ **Date of Birth** _____

Patient Name_____ **Date of Birth** _____

Address_____

_____ **Phone Number**_____

Medical information is to be

(_____) obtained from, or (_____) sent to:

The following Medical facility:

Name_____

Address_____

_____

Phone number_____ Fax number_____

Altamonte Pediatric Associates
(407) 831-6200

Altamonte □	**Lake Mary** □	**Apopka** □
475 Osceola St #1100	101 N. Country Club Rd #115	2271 E. Semoran Blvd
Altamonte Springs, FL 32701	Lake Mary, FL 32746	Apopka, FL 32703
Fax 407-831-1068	Fax 407-330-1140	Fax 407-814-0263

www.altamontepediatrics.com

Type of information shall include (_____) Complete Record (_____) Immunization Record (_____) Newborn Records

OR

(_____) Authorization to disclose is limited to the following _____

I understand that this consent is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization, and that the office has been taken in reliance on this authorization, and that consent shall remain for one year unless otherwise specified (_____) in order to effect the purpose for which it is given.

Mental Health, alcohol, drug abuse, HIV & or AIDS information is confidentially protected by Federal and State Law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations.

Parent or Legal Guardian_____Date,_____/____/_____

Relationship _____ Social Security Number_____

Witness_____Date, ____/_____/_____