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 □
475 Osceola St #1100
Altamonte Springs, FL 32701
Fax 407-831-1068

Lake Mary □
101 N. Country Club Rd #115
Lake Mary, FL 32746
Fax 407-330-1140

Apopka □
2271 E. Semoran Blvd
Apopka, FL 32703
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, ____/_____/_____