Small World Pediatrics, P.A.

2527 Windguard Circle, Ste 102, Wesley Chapel, FL 33544
Phone (813) 907-8001 • Fax (813) 907-5744

MEDICAL RECORDS RELEASE

Patient Name: _____ Date of Birth: _____ /_____ /_____

I authorize release **FROM**: ☐ Small World Pediatrics, 2527 Windguard Circle, Suite 102, Wesley Chapel, FL 33544

OR ☐_____ (Name of Business/Hospital/School)

Street Address _____

City _____ State _____ Zip _____

I authorize release **TO**: ☐ Small World Pediatrics, 2527 Windguard Circle, Suite 102, Wesley Chapel, FL 33544

OR ☐_____ (Name of Business/Hospital/School)

Street Address _____

City _____ State _____ Zip _____

Phone: (_____) _____ Fax: (_____)_____

Purpose of Release: ☐ Continuity of Care - Visit Notes & Immunization Records ☐ Legal (Attorney/Court)
☐ Personal Information ☐ Disability Insurance ☐ Other: _____

I specifically authorize the Use and/or Disclosure of the following Health Information and/or Medical Records, If they exist:
☐ Entire Medical (ALL information) ☐ Office Note & Reports ☐ Laboratory Reports ☐ Prescription History
☐ Transcribed Hospital Reports ☐ Diagnostic Reports ☐ Billing Statements ☐ Other: _____

The following items MUST BE INTIALED to be Included in the Use and/or Disclosure:

_____ HIV/AIDS relate information and/or records, HBV, TB or Other Communicable Diseases

_____ Mental Health Information and/or Records

_____ Domestic Violence

_____ Genetic Testing Information and/or records

_____ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.)
Describe: _____

_____ Other: _____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.
I, further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.
Finally, I understand that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date): _____.

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified above:

_____ _____
Name of Parent/Guardian/Patient (Circle One) Parent/Guardian/Patient (Circle One)

_____ _____/_____/_____
Signature of the Parent/Guardian/Patient (Circle One) Date Signed

Rev. 12/03/18