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ISLAND COAST PEDIATRICS

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Terry L. Warren, PA-C
Elizabeth Scanlon, ARNP

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Authorization for Release of Medical Information

*******All sections must be **COMPLETED** to process request*******

_____ **Patient's Full Legal Name (Please print)**

_____ **Patient's Date of Birth (mo/day/year)**

_____ **Street Address (where patient lives)**

_____ **Home Phone Number (including area code)**

_____ **City, State, Zip Code**

_____ **Alternate Phone Number (including area code)**

Please check if records are coming to or from Island Coast Pediatrics.

☐ **To:** **Island Coast Pediatrics**
☐ **From:** 12550 Professional Park Dr. Suite 11
Fort Myers, FL 33913
Phone: (239) 768-2111
Fax: (239) 482-4404
We prefer records to be faxed

_____ **Parent or Physician Name**

_____ **Street Address, City, State, Zip Code**

_____ **Phone and Fax Number**

☐ I will **Pick up** records at the following office: ☐Fort Myers ☐Estero ☐Cape Coral
☐ **Fax** records to: _____
☐ **Mail** records to Address indicated above (see fee policy below)

Records Requested: ☐Immunizations ☐School/Daycare Forms ☐All Records ☐Other: _____
Reason for Release: ☐Transfer of Care due to: _____ ☐Specialist ☐Personal Use

Per HIPAA Regulations you must check one box for each line below for all record requests.

☐ I Do or ☐ I Do Not authorize the release of: **Psychological/ Psychiatric conditions**
☐ I Do or ☐ I Do Not authorize the release of: **Drug/Alcohol information**
☐ I Do or ☐ I Do Not authorize the release of: **HIV/AIDS information**

Island Coast Pediatrics takes necessary steps to protect our patient's private health information. I authorize disclosure and release of the health information for myself or for the patient noted above. **If patient is 18 yrs or older, he or she must sign this release form.** This authorization is valid for 90 days from the date of request below. I understand I may cancel this request with written notification; however, this would not affect information released prior to my cancellation request.

The first request for medical records is provided at no charge; however, a fee may apply to records being mailed. I understand I am financially responsible for additional copies at the cost of $1.00 per page for the first 25 pages and .25 cents for each additional page. I understand the requirements of this authorization release and voluntarily consent to the release of my record or my child's record to where I have indicated above. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected by Federal Privacy Rules. Medical Records may take 7-10 business days from the date of receipt to process your request. Please let us know if you have any questions regarding this authorization release form.

_____ **Print** Parent or Guardian Name of Minor

_____ **Signature** of Parent or Guardian of Minor *(Or Signature of Patient if 18 yrs or older)*

_____ **Date** of Request

****

Office Use Only: _____ *Employee who received Auth Release*

_____ *Employee who faxed Auth Release to Physician or Facility*

Revised 01/31/14