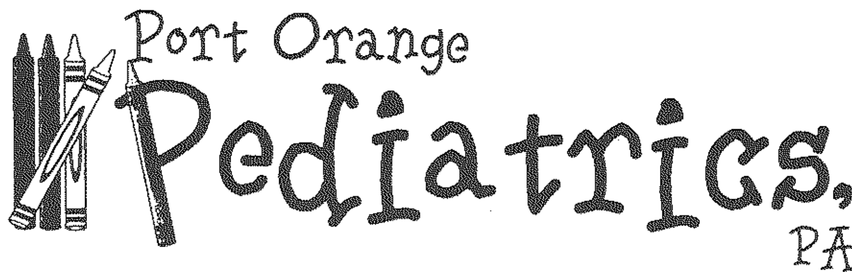

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name______________________________ Date of Birth:________________

Patient's Name______________________________ Date of Birth:________________

Patient's Name______________________________ Date of Birth:________________

I request and authorize **Port Orange Pediatrics, PA** to obtain healthcare information of the patient(s) named above from:

Name ____

Address ____

Phone number_____________________________ Fax ___________________________

This request and authorization applies to:

☐ I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive from the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐I authorize the release of any records regarding drug, alcohol, or mental health treatment fro the person(s) listed above.

☐ Healthcare information relating to the following treatment, condition, or dates:____

☐**All healthcare information**

____ Date signed__________________
Parent/Legal Guardian or Patient Signature

1728 Dunlawton Ave., Suite #1 · Port Orange, FL 32127 · Phone: 386-322-5390 · Fax: 386-322-5391