

EFFECTIVE JULY 1, 2003

**FEE FOR COPYING OF ALL PATIENT
RECORDS**

\$1.00/PAGE (1-25)

\$0.25/PAGE (26-)

(This is payable by the parent/guardian)

(PER FLORIDA STATUE 395.3025)

**A SIGNED RELEASE IS REQUIRED FOR
ALL REQUESTS**

**PLEASE ALLOW 3-5 BUSINESS DAYS
FOR PROCESSING AND MAILING OF
THE REQUESTED RECORDS**

**DUE TO HIPAA REGULATIONS OUR
PRACTICE DOES NOT FAX RECORDS
WE WILL ONLY MAIL
REQUESTED RECORDS
TO ADDRESS ON RELEASE**

Authorization to Release Patient Information

Patient Name: _____ Date of Birth: _____

I hereby consent to the disclosure of the specific information listed below, as it concerns the above named patient of Pediatric Otolaryngology Head & Neck Surgery Assoc., PA.

I am authorizing: Pediatric Otolaryngology Head & Neck Surgery Assoc, PA
PO Box 76479
St. Petersburg, FL 33734

Telephone: (727) 329-5400 Fax: (866) 229-1589

To release the medical records contained in the above named patient's medical record:

Date(s) of Treatment: From: _____ To: _____
Re: the Diagnosis of: _____
Other: _____

Please forward these records (as specified above) to:

Name of Outside Facility/Physician: _____

Mailing Address: _____

Telephone #: _____

Please forward these records by the following method of communication:

US Postal Mail []

I will pick up at the _____ office [] (Must arrange with staff member)

Signature of Legal Representative Date of Signature

(This signature is valid for one (1) year from the above "Date of Signature".

Relationship to Patient Phone # where you may be reached

***PLEASE NOTE:**

Only test results, the office visit notes and/or surgery notes of the physicians/physician extenders of Pediatric Otolaryngology Head and Neck Surgery Assoc., PA will be copied and forwarded for this request (unless otherwise noted).

07/04