Medical Records Release Authorization

To whom it may concern:
I hereby authorize the release of my child's medical records, or copies of such, and request that they be transferred from your office to Rainbow Pediatric Center at the contact information below as soon as possible.

Rainbow Pediatric Center
4788 Hodges Blvd. B-108 Jacksonville, FL 32224 Ph: 904.223.9100 Fax: 904.223.9282

Previous Provider Information
Office Name: ____

Address: ____ City: _______________________________

State: __________ Telephone: (_____) ________ - __________ Fax: (_____) ________ - __________

Check the reports to be disclosed:
□ **Complete Records** □ **Immunizations** □ Lab Results □ Growth Charts
□ Radiology Reports □ Operative Reports □ Consultations □ Summary of Visits

Below is my child's information for the records that I am requesting: ONLY ONE CHILD PER FORM

Name: ____DOB: _____ / _____ / __________

Reason for Requested use or Disclosure: □Change in Healthcare Provider □Legal □Personal use □2nd Opinion
□Other:___________ This authorization expires in 6 months from the date signed or earlier if needed: ___/___/___

□ DAYCARE / SCHOOL RELEASE: I authorize Rainbow Pediatrics to fax my child / children's medical information to:

Name: ____ Fax number: (_____)_____-__________

I understand the following:

- I may revoke this authorization at any time by providing written notice to the practice.
- I may not be able to revoke this authorization if the practice has already taken action utilizing this authorization or if the authorization was obtained as a condition of obtaining insurance coverage.
- The practice will not condition treatment or payment based on my signing this authorization.
- I am signing this authorization freely and under no pressure from any individual to do so.
- Information disclosed under this authorization might be re-disclosed by the recipient & this re-disclosure may no longer be protected by federal/state law.
- I acknowledge that I have had an opportunity to review this authorization and understand the intent and use.
- This authorization may include disclosure of information relating to alcohol and drug use, and confidential HIV related information only if I check this box and write my initials beside □ ________
- If I am authorizing the release of HIV related, alcohol, or drug treatment information, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal and state law. I understand that I have the right to request a list of people who may receive or use my HIV relation information without authorization.

Parent's Name : ______________________________________**Relationship to child**: ______________________

Parent's Signature: ___________________________________ **Date**:___/___/_____ **Phone**:_______________