

AUTHORIZATION TO RELEASE MEDICAL RECORDS

(In areas other than your signature please print with a pen only.)

Patient's Name: _____ Patient's Date of Birth: ____/____/____

Patient's Social Security Number: _____ - _____ - _____

Parent or Guardian's Name: _____

I hereby authorize: Dr. Milton Aponte/Cornerstone Pediatrics **to release any and all information to** _____, pertaining to the aforementioned patient, including diagnosis' and medical records of any/and all treatment(s) and/or examination(s) rendered to the patient named above, to include but not limited to any Federal and State protected documents under Florida Statute 394.459(9) Psychiatric records; Florida Statute 397.053 and Florida Statute 396.112 Drug and/or Alcohol abuse records; Florida Statute 381.609(2) Human Immunodeficiency Virus test results (AIDS and related conditions). I am aware that the information released pursuant to this authorization is subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Rule.

PLEASE CHECK ONE:

_____ **Send all records**

_____ **Send Discharge Summary** only, for:

() All hospitalization records

() Hospitalization date(s) of: ____/____/____ to ____/____/____

_____ **Send Newborn Screen Only**

_____ **Send Immunization Record only**

_____ Indicate other records _____

I understand this authorization will expire in six (6) months, and that I may revoke this authorization at any time during this period by notifying the providing organization in writing.

Signature of Parent/Guardian: _____ **Date:** _____

Patient's relation to the signor: _____

Release records to:

(Name of doctor/practice)

(Address)

(City, State & Zip)

(Office Telephone Number)

OR

Fax patient's records to this number: (_____) _____