AUTHORIZATION FOR RELEASE OF CONFIDENTIAL PATIENT INFORMATION

FACILITY/DOCTOR NAME:_____

ADDRESS: _____

_____

TELEPHONE: _____ FAX NUMBER: _____

PATIENT NAME: _____ DOB: _____

I hereby authorize & request the release of the following information to Premier Pediatrics:

☐ Full Medical Record

☐ Immunization Record

☐ Physical Exams and Growth Charts

☐ Specified Items Requested

Fax or Paper Copies only. No CDs!

Please mail or fax the requested information to:
Premier Pediatrics of Palm Beach
224 Chimney Corner Lane, Suite 2032
Jupiter, FL 33458
Phone Number: 561-469-8989
Fax Number: 877-409-2605

Any information, including diagnosis and records of treatment or examination rendered to me including any Federal and State protected information under appropriate Statue, Mental Health, Psychotherapy, Substance Abuse, Human Immunodeficiency Virus (AIDS) test results; and treatment. I understand that this authorization will remain in effect for (1) year until I revoke it in writing, to an authorized employee of Premier Pediatrics.
I have read Premier Pediatrics' Notice of Privacy. I hereby release Premier Pediatrics and its employees from any and all liability that may arise from the release of information as I have directed.

_____ _____
Signature of Parent or Guarantor Date

_____ _____ _____
Signature of Empowered Representative Relation to Patient Date