Jacksonville Pediatrics
2606 Park Street
Jacksonville, FL 32204
904-388-4646 fax 904-388-9017 www.jaxpeds.com
Randolph Thornton MD, Thomas Stanley MD, Nan McClelland MD, John Waidner MD

Authorization for Release of Protected Health Information

Child's Name:____ Date of Birth:____________

I hereby authorize information to be released from:

Practice Name: ____
Address: ____
City, State, ZIP ____
Fax Number: ____

To:

Name/Practice Name: ____
Address: ____
City, State, ZIP: ____
Fax Number: ____

The type of information to be released is as follows:
(Check all appropriate boxes)

- ☐ Office visits
- ☐ Lab results
- ☐ X-ray and/or imaging reports
- ☐ Specialist reports
- ☐ Immunization records
- ☐ Entire medical record

The information I am releasing is intended for the following use:

- ☐ My personal records
- ☐ Use by another health care provider
- ☐ Other___________________________

I understand that the information in the health records may include information relating to sexually transmitted disease, including HIV. It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.

I understand that I have the right to revoke this authorization at any time. This must be done in writing. I understand that Jacksonville Pediatrics has a privacy policy and that this policy is available for me to review at any time on request. This authorization will expire one year from the date below.

Signature of Parent or Guardian :________________________________Date:_________________

Print Name:________________________________Relationship to Patient:___________________