JACKSONVILLE PEDIATRICS

PEDIATRIC THROUGH ADOLESCENT MEDICINE
2606 PARK STREET
JACKSONVILLE, FL 32204-4594
904-388-4646

RANDOLPH E. THORNTON, M.D.
NAN S. MCCLELLAND,M.D.
THOMAS P. STANLEY, M.D.
JENNIFER A. SAVARESE, M.D.
RYAN CANTVILLE, DO

FAX NUMBER 388-9017

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION:

CHILD'S NAME: _____DOB:_____

I hereby authorize information to be released from:

PRACTICE NAME: _____
ADDRESS: _____
CITY,STATE,ZIP: _____
FAX NUMBER: _____

TO:
NAME _____
ADDRESS: _____
CITY,STATE,ZIP _____
FAX NUMBER: _____

- Office visits
- Lab results
- X-Ray and /or imaging reports
- Immunizations 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 my include information relating to sexually transmitted diseases, 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_____