BENNETT PEDIATRICS, LLC
Phone: 352.404.7728
Fax: 352.404.7724
365 Citrus Tower Blvd Ste 104
Clermont, FL 34711-6532
www.BennettPediatrics.com

Bennett PEDIATRICS
CARING FOR THE CHILD. CARING FOR THE FAMILY.

AUTHORIZATION FOR MEDICAL RECORD RELEASE

SECTION I (Must be completed for ALL Authorizations)

Date _____/ _____/ _____

PATIENT'SNAME:_____AGE:_____DATEOFBIRTH:_____

HOME ADDRESS: _____

Persons/organizations providing the information (Complete with address):

_____

_____

_____

Persons/organizations receiving this information (Complete with address):

_____

_____

_____

Specific description of information (including dates) to be used and/or disclosed about me:

_____

_____

_____

_____

*The following items must be initialed to be included in the use or disclosure of other health information:

_____ *HIV / AIDS related health information and/or records

_____ * Mental health information and/or records

_____ * Genetic testing information and/or records

_____ * Drug/alcohol diagnosis treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the disclosure of such information.)

SECTION II (Bennett Pediatrics LLC has requested this authorization at the patients or patient's representatives request or direction)

The patient or the patient's representative **must read and initial** the following statements:

_____ I understand that my health care and the payment for my healthcare will NOT be affected if I DO NOT sign this form.

_____ I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

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[CONTINUED]

SECTION III (Must be completed for ALL Authorizations)

The patient or the patient's representative must read and initial the following statement:

I understand that this Authorization will expire. (Please choose one.)

_____ No expiration (permitted only for Authorization used to create or maintain research databases or repositories).

_____ On _____/_____/_____

Signature of Patient or Patient's Representative (form must be completed before signing):
_____ Date: _____

Print Name of Patient's Representative: _____
Relationship to the Patient: _____