DOLPHIN PEDIATRICS, LLC
9850 STIRLING ROAD, SUITE 103
COOPER CITY, FL 33024
TEL (954) 362-3200 - FAX (954) 362-3205

REQUEST TO RELEASE OR COPY MEDICAL RECORDS

PATIENT NAME(S):_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

ADDRESS: _____ PHONE: _____

_____

FOR RECORD RELEASE: By signing this authorization, I authorize the entity or physician listed below to use and/or disclose certain protected health information about me and/or my child. I also understand that I may revoke this authorization at any time, in writing, to the address listed below provided the information has not been released.

FOR COPIES: I understand and agree that I am financially responsible for the cost associated with my request. I understand that the charge for a fax request is $10.00. I understand that the charge for a paper copy is $10.00 + $0.15 per page.

THIS AUTHORIZATION PERMITS PHYSICIAN THAT HOLDS YOUR RECORDS NOW

NAME: _____

ADDRESS: _____

_____

TEL: _____

FAX: _____

TO DISCLOSE TO

NAME: **DOLPHIN PEDIATRICS LLC.**

ADDRESS: **9850 STIRLING RD SUITE 103**

COOPER CITY, FL 33024

TEL: (954)362-3200

FAX: (954)362-3205

The following information

- ☐ OFFICE NOTES for these dates: _____
- ☐ LAB/RADIOLOGY RECORDS for these dates: _____
- ☐ IMMUNIZATIONS AND GROWTH CHARTS
- ☐ ALL OF THE ABOVE
- ☐ OTHER _____

REASON FOR RECORD RELEASE OR COPY:

☐ Personal copy ☐ Over age 21 ☐ Referral for a specialist

☐ Moving ☐ Transferring to another practice ☐ Other: _____

This authorization shall not be valid for more than 12 months after date of signature. I understand that after the custodian of records discloses my health information, federal privacy laws may no longer protect it. I further understand that this authorization is voluntary and that I may refuse to sign it. My refusal will not affect my ability to obtain treatment or be eligible for benefits unless allowed by law. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit or otherwise restrict my ability to authorize the use of this information.

_____

PRINTED NAME OF PARENT/GUARDIAN or PATIENT IF 18+

SIGNATURE OF PARENT/GUARDIAN or PATIENT IF 18+ **DATE**