Pinecrest Pediatrics Group, LLC
11635 South Dixie Highway
Pinecrest, FL 33156
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HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION PURSUANT TO 45 CFR 164.508

TO: Health Care Provider: _____

Street Address, Tel, Fax:_____

RE: Patient/Patients' Name: _____

Date/Dates of Birth: _____

I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following to Pinecrest Pediatrics Group, LLC.

Medical records

- Complete Immunization Record
- Copy of all Growth Charts
- Copy of last well child exam
- Problem list
- All physical, occupational and speech therapy consultations and progress notes.
- All laboratory and radiology reports.

Extent of Authorization

- I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

I understand that you will provide this information within 30 days of receipt of this request, as required by the Florida State Board and the HIPPA Privacy Rule.

This authorization shall be in force and effect until two years from date of execution at which time this authorization expires.

_____

Name, Relationship, Signature of Legally Authorized Representative to Patient Date
(See 45CFR §164.508(c)(1)(iv))