Medical Records Release Form

Sawgrass Pediatric Partners LLC

Please complete <u>one</u> form per child

Patient Name: _____ **Date of Birth:**_____

Patient Address: _____ **Phone #** _____

Street Address

_____

City, State, Zip

New Patients coming to Sawgrass Pediatrics

I authorize: **To release the above patient's medical records to:**

_____ _____

<u>Previous</u> Primary Care Provider (PCP) or Specialist's Name **Sawgrass Pediatric Partners**

_____ _____

Street Address **Street Address**

_____ _____

City, State, ZIP **City, State, ZIP**

_____ _____

Phone number _____ **Phone number** _____

By signing this authorization, I authorize the above listed PCP or specialist to disclose certain protected health information (PHI) about the patient listed above.

There will <u>not</u> be any charge for medical records that are sent <u>from PCP or specialist to PCP or specialist</u>

There <u>will be</u> a monetary charge for medical record that will be sent <u>from PCP to a patient, patient's legal guardian</u> or Legal Agent as described below

( ) **Paper** and/or ( ) **Electronic**

I understand and agree that I am financially responsible for the following fees associated with my request for medical records to be sent from the PCP or specialist to me, the patient, or to me, the patient's legal agent:

Copying charges include the cost of supplies, electronic devices, labor related to the production of this information and postal charges.

I understand that the charge for paper copy is: **$1 each page but not to exceed $25.00 total**

(Costs for reproducing medical records are in accordance with the FL Administrative Register Rule 64B8-10.003 and F.S. 164.524 ©4.)

***<u>Please indicate the specific information to be released</u>*:**

( ) **Complete medical record** – to be requested from a previous PCP or specialist when you are a new patient to Sawgrass Pediatrics

( ) Other: _____

***<u>Please indicate any information that you want excluded /not released with your request</u>*:**

( ) Mental Health Records ( ) Drug/Alcohol Treatment ( ) HIV Testing ( ) Sexual Assault/Victimization Records

( ) Other: _____

<u>Please indicate the reason you are requesting medical records to be released:</u>

( ) Personal copy (***charges apply)*** ( ) Transitioning to an adult PCP/specialist ( ) Change of Insurance ( ) Moving out of state

( ) Leaving Practice

( ) Unhappy with PCP (Please state why) _____

( ) Unhappy with Practice (Please state why) _____

***Please allow up to 30 days for processing**

_____ _____ _____

Signature of Patient or Legal Guardian Printed Name of Patient or Legal Guardian Date