AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION:

Name:_____ **DOB:** _____
Last First Middle

AUTHORIZES:_____
Name of Healthcare Provider City, State

Phone: _____ Fax: _____

TO DISCLOSE TO: Lane Pediatrics, PA
9260 Estero Park Commons Blvd.
Suite 100
Estero, FL 33928
P (239) 908-3593 F (239) 908-3597

DATE(S) OF INFORMATION TO BE DISCLOSED: From _____ to _____
Month/Year Month/Year

If left blank, only information from the past two (2) years will be disclosed.

INFORMATION TO BE DISCLOSED:
☐ All medical records related to (specify condition, treatment, etc): _____
☐ Radiology images/reports (specify test): _____
☐ Specific records/information as follows: _____
_____
_____

I DO NOT WANT THE FOLLOWING INFORMATION DISCLOSED:
☐Alcohol/drug abuse ☐ HIV test results ☐ Mental health

EXPIRATION: This authorization is good until the following date/event: _____
If this item is left blank, the authorization will expire in one (1) year from the date signed.

PURPOSE: ☐Further medical care ☐ Personal records ☐ Other_____

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: I agree to release the above named facility, it's affiliates, employees, and physicians from all legal responsibility and liability that may arise from the disclosure and/or unauthorized redisclosure of such information. I understand that I have a right to revoke this authorization at any time, and I must do so in writing. I understand that the revocation will not apply to the information which has already been released in response to this authorization. I understand that authorizing the disclosure of this health information is voluntary. I understand that I do not need to sign this authorization in order to receive treatment. I understand that I may inspect or copy the information to be used or disclosed.

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE: **DATE:**

_____ _____

Relationship: _____