Authorization for Release of Confidential Health Information

I, _____ (Parent/Legal Guardian) authorize RDV SPORTSPLEX PEDIATRICS to obtain/release the entire medical record of my child(ren).

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Patient Name _____ Date of Birth _____

Medical Information is to be

☐ **sent to** **or** ☐ **obtained from**

RDV SPORTSPLEX Pediatrics

and

☐ **sent to** **or** ☐ **obtained from**

the following facility/entity:

Name: _____

Address: _____

Phone: _____ Fax: _____

For the purposes of: ☐ **Transferring out** ☐ **Personal use** ☐ **Specialist**

I understand that this consent is revocable upon written notice where the original authorization is retained, except to the extent that action has already been taken on this authorization, and that the office has been taken in reliance on this authorization, and that consent shall remain for one year unless otherwise specified in order to effect the purpose for which it is given. Mental health, alcohol and/or drug abuse, HIV and/or AIDS, sexually transmitted diseases and other similar conditions are confidentially protected by Federal State Law which prohibits disclosure without specific written authorization of the undersigned or as otherwise permitted by such regulations. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

USE ONLY IF TRANSFERRING OUT OF OUR PRACTICE (NOT FOR PATIENTS TRANSFERRING IN)
All files mailed or picked up are given on a CD in PDF format.

I would like the records to be: ☐ **picked up ($10 per child)** ☐ **mailed ($15 per child)**

or

☐ **I will obtain my own records at no charge through the Secure Patient Portal**

or

☐ **Courtesy copy ($0) – Last physical, shot record, growth chart and problem list ONLY**

Parent/Legal Guardian: _____ Relationship to Patient(s): _____

Signature: _____Date: _____

For assistance with transferring your records to/from our office
please contact Maria in the Records Department at 407-916-4520 or maria@rdvpediatrics.com