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 ______________

Address ____ Phone ___________________

Medical information is to be

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

8701 Maitland Summit Blvd
Orlando FL 32810
Phone: 407-916-4520 Fax: 407-916-4525

and

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

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 full records to be: ☐ **picked up ($10 per child)** ☐ **mailed (+$5 per family)**

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 or from our office, please contact Maria in the Records Department at 407-916-4520 or maria@rdvpediatrics.com