AUTHORIZATION TO OBTAIN
RELEASE OF PROTECTED HEALTH INFORMATION

(Request for Release of Medical Records)

I, ____ Hereby Authorize

____

(Hospital, Individual, Doctor's Office or Agency/*Nombre de Clinica/Doctor*)

____

Street or PO Box/ *Direccion*	City/ *Cuidad*	State/ *Estado*	Zip Code/ *Codigo postal*

To release the following information: (Choose all that apply) contained in

____ Medical Chart / Records.
(PATIENT NAME/NOMBRE DE PACIENTE)

Immunizations	___	Growth Chart	___
Lead level/labs	___	Specialists notes	___
Chronic problem list	___	Complete chart	___
Newborn record	___		

IF CHART/RECORDS ARE MORE THAN 10 PAGES, PLEASE MAIL TO:

HEARTLAND PEDIATRICS OF LAKE WALES, LLC
1354 State Road 60 East
Lake Wales, FL 33853
Phone: 863-679-8888
Fax: 863-676-2851

I understand that this consent is revocable upon written notice to the Clinic or physician, except to the extent that action by the Clinic or Physician has been taken in reliance on this authorization, and that this authorization shall remain in force for a twelve-month period. (Expiration date: _______________). In order to not affect the purpose for which it is given, Alcohol and Drug abuse information, if present has been disclosed from records whose confidentiality is protected by federal law. Federal Regulation (42CFR, Part!!) prohibits making further disclosure of it without the specific written authorization of the undersigned, or as otherwise permitted by Such Regulation.

Date of Authorization: ________________ Date of Birth of Patient: ________________
(Fecha de hou) *(Fecha de Nacimiento)*

Social Security #: ________________________________ *(Numero seguro social)*

Identification Shown: ______________________________ *(Identificacion)*

Parent or Legal Guardian's Signature: ______________________________________
(Firma del Padre/Madre o guardian)

Witness: ____ *(Testigo)*

Updated 2/4/16