# Celebration Pediatrics
# 410 Celebration Place Suite 206
# Celebration, FL 34741
# 407-566-9700(phone)
# 407-674-2254(fax)


AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize _____
to release to _____
the following information from the medical records of :

Name _____ Date of Birth _____
Name _____ Date of Birth _____
Name _____ Date of Birth _____
Name _____ Date of Birth _____

Mom's Name _____ Date of Birth_____

**PLEASE SEND US**
_____ Immunizations, Problem List and Growth Charts
_____ Copy of complete medical records
_____ Lab & X-Ray reports
_____ Birth Records and Infant Screen (PKU)

This release, and all authority to disclose information pertaining to me, shall expire on _____ or one year from the date of the signature below, unless earlier revoked by me in writing.

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse. I authorize the release or disclosure of this type of information.

I understand the following: See CFR §164.508(c)(2)(i-iii)

a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released in reliance upon this authorization.
b. The information released in response to this authorization may be re-disclosed to other parties.
c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

Signed: _____ Date: _____
Patient's Legal Guardian

_____ Witness: _____
Relationship to Patient