



# Jacksonville Beach PEDIATRIC CARE CENTER

274 Third Ave. S. • Jacksonville Beach, FL 32250 • Phone 904.249.3373 • Fax 904.249.3375

## REQUEST FOR RELEASE OF MEDICAL RECORDS

I hereby authorize \_\_\_\_\_ to release copies of the medical records for the following:  
(where the records are coming from)

Child's Name

Date of Birth

Child's Name

Date of Birth

Release these medical records to the following name and address:

Jacksonville Beach Pediatric Care Center  
274 Third Ave S.  
Jacksonville Beach, FL 32250

Please release:

Complete Record  Summary Copy Only

Other, Please Specify: \_\_\_\_\_

Reason for the records being released is as follows:

Relocation  Change in Insurance  Release to Specialist

Other, Please Specify: \_\_\_\_\_

Advance notice must be given to allow our staff ample time to get these records copied. Record must be sent to another physician or the parent / guardian must pick them up. This authorization will expire one year from the date below, unless otherwise specified:

I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS or HIV. It may also include information about behavior or mental health services, and treatment for alcohol and drug abuse.

I understand that I have a right to revoke this authorization at any time except to the extent action has been taken prior to revocation. I understand that if I revoke this authorization, I must do so in writing to the address of the releasing institution. I understand that, if this information is disclosed to a third party, the information may no longer be protected by federal privacy regulations and may be redisclosed by the person or entity that received the information in accordance with Florida law. I also understand I may be charged for copies of this information in accordance with Florida law. I understand the matters discussed on this form. I release the provider, and all persons associated with this company from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein. I understand I do not have to sign this authorization in order to obtain healthcare treatment.

Signature of Parent or Guardian

Date

Print Name of Parent or Guardian

Relationship to Patient

Address of Parent

Phone Number