South Tampa Kids Pediatric Care
Permission to Release Medical Information

Toni Glatchak, APRN, PNP-PC
3314 Henderson Blvd Suite 100B
Tampa | Florida | 33609
P: 813-801-KIDS (5437) F: 813-822-0296

PATIENT INFORMATION

Patient Name:	DOB: ____ / ____ / _____
Patient Name:	DOB: ____ / ____ / _____
Patient Name:	DOB: ____ / ____ / _____
Patient Name:	DOB: ____ / ____ / _____

PERMISSION TO RELEASE MEDICAL INFORMATION TO

Name:	Relationship to patient:
Name:	Relationship to patient:
Name:	Relationship to patient:
Name:	Relationship to patient:

AUTHORIZATION (INITIAL ALL THAT APPLY)

__________	Access to all medical records and below topics.
__________	Access to all medical records excluding confidential files (i.e. mental health, HIV, STD, or pregnancy).
__________	Discuss my care with my provider.
__________	Discuss pharmacy | prescription records only.
__________	Schedule appointments (well, sick, or consultations).
__________	Receive orders and results for x-ray | radiologic imaging.
__________	Receive laboratory results (including HIV or other STD results).
__________	Other, please specify:

SIGNATURE

Print Name:

X	
Signature of Patient | Parent | Guardian | Responsible Party I authorize the above listed person(s) access to my medical information (specific approval access above). ***In the event I would like to append my authorization, it is my responsibility to update this information.***	Date Signed

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