South Tampa Kids Pediatric Care Medical Record Release

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P: 813-801-KIDS (5437) F: 813-822-0296

Notes: Patient Name: DOB:	RELEASE OF MEDICAL RECORDS TO STK PEDIATRIC CARE PATIENT (S) INFORMATION				
Patient Name: Patient Name: Patient Name: Patient Name: Patient Name: RELEASE RECORDS FROM Facility Name: Phone: RELEASE RECORDS FROM Facility Name: AUTHORIZATION (INITIAL EACH ITEM BELOW) I understand the information in my health record includes confidential and personal information. I understand once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. I understand authorizing the use or release of this information is voluntary. I need not sign this form to ensure health care treatment. SIGNATURE Print Name: X Signature of Parent Guardian Responsible Party Date Signed This authorization will expire on (insert date or event): I'l fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed WITNESS Print Name:	Notes:	1711121(1 (0)	I (I ORMITIO)		
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