South Tampa Kids Pediatric Care
Medical Record Release

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RELEASE OF MEDICAL RECORDS TO STK PEDIATRIC CARE
PATIENT (S) INFORMATION

Notes:

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

RELEASE RECORDS FROM

Facility Name:	Phone:	Fax:
Address:		

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): ____

If I 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:

X	
Signature	Date Signed

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