WholeKids Pediatrics
Jacksonville, FL (P) 904.479.2393 Email: wholekidspediatrics@gmail.com

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

_____ _____
Patient Name Date of Birth

_____
Address

_____
City, State, Zip

_____
Email Address (records will be sent via an encrypted secure link)

I, _____, hereby authorize and request that **WHOLEKIDS PEDIATRICS** release information from the above named patient's medical records, including laboratory results, radiologic testing results, medications, hospitalization information, office notes, and treatment plans. I understand that this authorization will expire in 30 days, and that it may be revoked at any time in writing. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient or third parties and no longer protected by the HIPAA privacy rule.

I acknowledge that my records may include sensitive material. Therefore, I request that you include all records, and any of the following sensitive records (initial by categories to be <u>included</u> in records provided):

___ Substance Abuse ___ AIDS/HIV/STDs ___ Psychological/Psychiatric Conditions ___ Genetic Testing

Date:_____

_____ _____
Signature of Patient or Legal Guardian Relationship to patient