Advanced Kids Care, PA

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Patient's Name:_____D.O.B._____

We are requesting medical records from: _____
(Physician / Facility)

Address:_____City:_____State:_____
Phone:_____Fax:_____

I hereby request that all medical records be released to: **Advanced Kids Care, P.A.**

TYPE OF INFORMATION TO BE RELEASED OR DISCLOSED IS AS FOLLOWS:

_____Physician Progress Notes Dates:_____
_____History and Physical Dates:_____
_____Laboratory Results Dates:_____
_____Radiology Reports Dates:_____
_____Other Dates:_____
_____Entire Record Dates:_____

Reason for Disclosure:

_____continuing Medical Care _____Insurance _____Attorney _____Personal _____Other _____

I understand that:

- By signing this form I am authorizing the release of my protected health information.
- I may revoke this authorization at any time with written notification but it will not affect information that has already been released.
- Federal Privacy laws will protect information going to a health care provider or plan covered by federal privacy laws.
- Information received at other facilities may not be protected and may be re-disclosed by that facility.

_____ _____
Guardian Date:

_____ _____
Witness Dates:

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