Children's Physicians

Authorization for Release of Confidential Patient Information

Practice Name:_____

Address:_____

City/State/Zip:_____

Phone:_____Fax:_____

Patient Name_____DOB_____

I hereby authorize and request the release of the following information to Children's Physicians

- Full Medical Records
- Immunization Records
- Physical Exams and Growth Charts
- Specified Item Requested:_____

Please mail or fax the requested information to:

Children's Physicians 3365 Burns Road Suite 100 Palm Beach Gardens, Fl 33410 561-626-4000 561-626-8956 Fax	Children's Physicians 270 S. Central Blvd Suite 104-B Jupiter, Fl 33458 561-743-9000 561-743-9005 Fax	Children's Physicians 2676 SW Immanuel Dr Palm City, Fl 34990 772-219-4444 772-219-0550 Fax

Any information including diagnosis and records of treatment or examination rendered to me including any Federal and State protected information under appropriate Statue, Mental Health, Psychotherapy, Substance Abuse, Human Immunodeficiency Virus (AIDS) test results and treatment. I understand that this authorization will remain in effect for one year or until revoked in writing, to an authorized employee of Children's Physicians.

I have read Children's Physicians Notice of Privacy, I hereby release Children's Physicians and their employees from any and all liability that may arise from the release of information as I have directed.

_____ _____

Signature of Patient or Guarantor Date

_____ _____ _____

Signature of Legal Representative Relation to Patient Date