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

IF THERE ARE MORE THAN 40 PAGES, PLEASE MAIL THE DOCUMENTS.

- □ Last office visit
- □ Last physical exam
- □ Growth charts
- □ Diagnosis/Problem List
- □ Immunization records
- □ Imaging:_____

Please fax (preferable) or mail the requested information to:

Children's Physicians 3365 Burns Rd., #100 Palm Bch Gdns, FL 33410 561-626-4000 561-626-8956 Fax	Children's Physicians 270 S Central Blvd #104B 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 y ear 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 Guarantor/Legal Representative Relation to Patient Date