PEDIATRIC ASSOCIATES AT ARGYLE, P.A.

CONSENT FOR RELEASE OF INFORMATION

DATE: ____

I HEREBY AUTHORIZE RECORDS TO BE RELEASED FROM:

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____
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PATIENT: ____
(please print)

PATIENT DOB: _______________________**PATIENT SS#**: _______________________________

COVERING THESE DATES OF SERVICE: ____________________TO ________________________

OR ALL _____________________

INFORMATION TO BE RELEASED: **Copy of health record**

G Contents of entire medical chart including alcohol abuse, mental health and infectious disease.
G Exclude information on alcohol abuse, mental health and infectious disease.
G Exclude information from any other doctors, facilities, etc.

INFORMATION TO BE RELEASED TO: PEDIATRIC ASSOCIATES AT ARGYLE, PA
8351 WESTPORT ROAD
JACKSONVILLE, FL 32244
TEL. 904-317-8811

PURPOSE OF RECORDS RELEASE: ____

I understand this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on this consent. **This consent will expire in 90 days**.

This facility, its employees and officers and attending physicians are released from legal responsibility or liability for the release of the above information.

____
Signature of Patient

____________________________________ ____________________________
Signature of Patient Representative Relationship to Patient