coastal pediatric group

Susanna Buchholz, MD Lyn Sprenkle, MD

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name:_____ DOB:_____
Street Address:_____ City/State/Zip:_____
Phone Number:_____ Email:_____

Please OBTAIN Information FROM:
Name of Provider/Clinic:
_____
Street Address:
_____
City/State/Zip:
_____
Fax:
_____

Please SEND Information
TO: Name of Provider/Clinic:
Coastal Pediatric Group
Street Address:
91 Mack Bayou Loop
City/State/Zip:
Santa Rosa Beach, FL 32459
Fax:
850-249-1309

I AUTHORIZE the following information to be disclosed:

- Complete Health Records
- Immunization Record
- Growth Charts
- Well Child Visits
- Progress Notes
- Consult Notes
- Medication History
- Other:

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

EXPIRATION of this Authorization:

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

ADDITIONAL PATIENT INFORMATION:

If I fail to specify an expiration date, event or condition, this authorization will expire in ninety days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Name of of Parent or Guardian:_____ **Relation to patient:**_____

Signature of parent or guardian:_____ **Date:** _____