LIGHTHOUSE PEDIATRICS OF NAPLES

Release of Health Information/Records

Please list all physician(s) names and fax numbers that records are to be released from:

Physician name:	Address:	Phone #:	Fax#:

Please mail records if more than 10 pages

Patient name: ______________________________ **Date of birth:** __________________

I. My Authorization

You may use or disclose the following health care information (check all that apply):

- O All my health information maintained by the above-named practice
- O My health information relating to the following treatment or condition: ____________
- O My health information for the date(s): ______________________________
- O Other: ____

You may disclose this health information to:

Lighthouse Pediatrics of Naples
3227 Horseshoe Drive South
Naples, FL 34104
Ph: 239-449-9882 Fx: 239-449-9884

Reason(s) for this authorization:

- O other (specify) ______________________________
- O at my request to provide continuity of care

Term:

- O This authorization ends on (date) ________________
- O indefinitely

II. My Rights

I understand that the release or transfer of the information specified to any person or entity not specified above is prohibited. An additional written consent must be completed for any proposed new use of the information or for its transfer to another person. I release and hold harmless Lighthouse Pediatrics of Naples and the physicians of the medical practice from all liability that may arise from complying with this authorization.

- O I understand that the medical records may contain medical and administrative information from other health care providers.
- O I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing. I understand that the revocation will not apply to the information that has already been released in response to this authorization.
- O I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

X______________________________________ ____________________
Patient or legally authorized individual signature Todays Date

X______________________________________ ____________________
Printed Name if signed on behalf of the patient Relationship to Patient