Authorization to Release Patient Information

Patient Name: _____ Date of Birth: _____

I hereby consent to the disclosure of the specific information listed below, as it concerns the above-named patient of Pediatric Otolaryngology Head & Neck Surgery Associates, P.A.

I am authorizing:

Pediatric Otolaryngology Head & Neck Surgery Associates, P.A.
PO Box 76479
St Petersburg, FL 33734
Telephone: (727) 329-5400
Fax: (727) 329-5401

To release the medical records contained in the above-named patient's medical record:
Date(s) of Treatment: From: _____ To: _____
The Diagnosis of: _____ Other: _____

Please release records (as specified above) to:
Name of Outside Facility/Physician or Parent/Guardian:_____
Mailing Address: _____
Address City State Zip
Telephone #: _____ Fax #: _____

Please forward these records by the following method of communication:
____ US Postal Mail
____ Fax
____ I will pick up at the _____ Office
____ via [SECURE] EMAIL: _____
(Parent/Guardian email address must match patient's chart)

WARNING: CONFIDENTIALITY NOTICE - The information enclosed with this transmission are the private, confidential property of the sender, and the material is privileged communication intended solely for the individual indicated. If you are not the intended recipient, you are notified that any review, disclosure, copying, distribution, or the taking of any other action relevant to the contents of this transmission are strictly prohibited. The information contained in this transmission may contain privileged and confidential information, including patient information protected by federal and state privacy laws. It is intended only for the use of the person(s) named above. If you are not the intended recipient, you are hereby notified that any review, dissemination, distribution, or duplication of this communication is strictly prohibited. If you are not the intended recipient, please contact the sender by reply email and destroy all copies of the original message. If you have received this transmission in error, please notify us immediately at medicalrec@pohns.net

_____ _____
Signature of Legal Representative Date of Signature
(This signature is valid for one (1) year from the above "Date of Signature.")

_____ _____
Relationship to Patient Phone number where you may be reached

PLEASE NOTE: Only test results, the office visit notes and/or surgery notes of the physicians/physician extenders of Pediatric Otolaryngology Head Neck Surgery Associates, PA will be copied and forwarded for this request unless otherwise noted. MAR2021