Volusia PEDIATRICS
Volusia County's Premiere Pediatric Center

Authorization for Release of Confidential Information

Parent/Guardian contact number: _____

I, _____, Parent or Guardian of

Patient Name: _____

Date of Birth: _____

Hereby authorize the release of medical records from:

Physician / Office / Hospital: _____

Address: _____

_____

Phone: _____

Fax: _____

TO: Volusia Pediatrics, LLC

317 South Dixie Freeway
New Smyrna Beach, FL 32168
Phone: 386 - 424 - 1414

633 Dunlawton Ave
Port Orange, Fl 32127
Fax: 386 - 424 - 9130

This authorization expires on_____ or sixty (60) days from the signature date.

Information to be released may include:
(mark all that apply)

- ☐ Complete Record
- ☐ Last Visit
- ☐ Lab/ X-Ray / Diagnostic Results
- ☐ Psychiatric
- ☐ Drug and/or alcohol abuse
- ☐ Shot Record
- ☐ Physical / Wellness Record
- ☐ Office Notes
- ☐ Consultation Report
- ☐ Patient History
- ☐ HIV / ARC / AIDS Testing
- ☐ Other _____ (Please Specify)

I understand that this consent is revocable upon written notice to **Volusia Pediatrics, LLC** except to the extent that action has already been taken on this authorization. Alcohol, drug, HIV, ARC, and/or AIDS information, if present, will be disclosed only if authorized. This information is confidentially protected by federal law, which prohibits disclosure without specific written authorization of the undersigned, or else otherwise permitted by such regulation. I further understand that I may select which information from the above list of confidential information will be released.

_____ _____

Parent / Guardian Signature Date