Tracey Burton-Lindner M.D.
Pediatrics of Okaloosa
850-678-9009
Fax: 850-678-3444
www.pediatricsofokaloosa.com
1001 W. College Blvd, Suite C, Niceville, FL 32578

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND PROTECTED HEALTH INFORMATION

Patient's Name: _____ DOB: _____

Address: _____ Phone #: _____

I hereby authorize _____ _____
Physician Name, Hospital Name, or Clinic Name — Phone #

_____ _____
Fax # — City, State & zip code

to release the following information ☐ My records (over 18yrs) ☐ My child's (under 18yrs) medical records ☐ during the period

to include: ☐ Medical transcripts/notes ☐ Lab reports ☐ X-Ray reports

Release records to: ☐ Pediatrics of Okaloosa, 1001 West College Blvd, Suite C, Niceville FL 32578
Fax: **850-678-3444**

or to: ☐ _____
Name & address of medical office

_____ - _____
Fax Number — Phone Number

I acknowledge and agree that I have read (or had someone read to me) the following statements:

- This authorization expires in 12 months from the date signed unless an alternative date, event, or "no expiration designated" is inserted here: _____ No further disclosures described above may be made after the expiration.
- I place no limitations on history or illness (including HIV and/or AIDS, genetic, drug dependency or psychiatric information) or diagnosed & therapeutic information, including any treatment for alcohol, drug abuse, or psychiatric disorders.
- I may refuse to sign this authorization and that it is strictly voluntary and that my treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke my consent at any time by submitting my revocation request in writing. The revocation of this request will not affect any health information disclosed prior to Pediatrics of Okaloosa receiving my written notice.
- I understand that information disclosed may be subject to re-disclosure and may no longer be protected by federal privacy regulations.
- I understand that I have a right to see & obtain a copy of the information described on this form, and/or a copy of this form for a reasonable copy fee, if I ask.

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By signing, I understand that I am authorizing Pediatrics of Okaloosa to ***release/obtain*** *information as described above. I hereby release Pediatrics of Okaloosa – Tracey Burton – Lindner & (associates, employees, medical staff members and agents) from any and all claims, liability, suits or costs related to the use of images or disclosure of the information and materials described herein*

_____ _____ _____
Signature – must be signed by patient if over 18 yrs of age — Date — Authority to act on behalf of patient (attach document)

If greater than ten (10) pages please mail records to the address above