SHUKLA PEDIATRICS
2501 S VOLUSIA AVE, SUITE 101
ORANGE CITY, FL 32763

Authorization to Release Medical Information

Select one: □ Transfer in □ Coordination of care (school)

Patient Name: _____ Date of Birth: _____

I request and authorize Name/Facility A to release health information to Name/Facility B:
From:

Name/Facility Address: _____

Phone Number: _____ Fax: _____

To:

Name/Facility B: SHUKLA PEDIATRICS

Address: 2501 S VOLUSIA AVE, SUITE 100 ORANGE CITY FL, 32763

Phone Number: (386) 789-9000 Fax: (321) 286-8171

This request for authorization applies to:

□ Immunization record only

□ Entire copy of Medical

□ Other: _____

I understand that:

- My right to healthcare treatment is not conditioned on this authorization
- Release of sensitive information regarding HIV/AIDS, Substance Abuse, and Sexually Transmitted Diseases, requires a separate release form.
- I may revoke this authorization in writing, but any previously disclosed information would not be subject to such revocation. I may inspect or copy the information to be used or disclosed and may refuse to sign the authorization.
- There may be a charge for the request of records.

I may revoke this authorization in writing, but any previously disclosed information would not be subject to such revocation. I may inspect or copy the information to be used or disclosed and may refuse to sign the authorization. My refusal to sign will not affect my ability to obtain treatment.

Guardian/Parent Signature: _____ Date: _____

Relationship to Patient: _____