



**AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS**  
Records To Be Released TO: MEDPEDS Associates of Sarasota, PA  
1931 S. Tuttle Ave., Sarasota, FL 34239  
Phone:(941) 955-8800 ~ Fax: (941) 955-8842

**Patient Information:**

\_\_\_\_\_  
Last Name First, Name Middle Initial

\_\_\_\_\_  
Street Address Phone

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Birth date Social Security Number

**Records Released From:** \_\_\_\_ *All of my healthcare professionals, as needed.*

\_\_\_\_\_  
Name – (Healthcare Facility, Physician...)

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
( ) ( )

\_\_\_\_\_  
Phone Number Fax Number

**INFORMATION TO BE RELEASED:** Complete Copy of All Records

**In compliance with Florida Statutes which require special permission to release otherwise privileged information, please release records pertaining to:**  
**(Check applicable conditions)**

- Mental Health
- Developmental Disabilities
- Drug Treatment/Evaluation
- Alcohol Treatment/Evaluation
- HIV Test Results

**PURPOSE OR NEED FOR DISCLOSURE: (Check all applicable categories)**

- Further Medical Care
- Payment of Insurance Claim
- Personal
- Other: \_\_\_\_\_

**This authorization will remain in effect until this request is processed unless you specify this authorization will be effective for an additional time period. Written consent is necessary to revoke this request.**

- Additional time period. Specify: \_\_\_\_\_
- None

**I authorize release of my records in accordance with the specification listed above. I understand that I have the right to inspect and receive a copy of the disclosed material. A photocopy of this consent shall be valid as the original.**

**X**  
\_\_\_\_\_  
**SIGNATURE of Patient/Guardian/Legal Representative**

\_\_\_\_\_  
**Date**