All Star Pediatrics
Where all of our kids shine!!
Dr. Darlene Eckert, MD
Board Certified Pediatrics
14065 Town Loop Blvd. Suite 300 - Orlando, FL 32837 | Phone: 407-240-5554 | Fax: 407-240-5543

AUTHORIZATION TO OBTAIN, RELEASE OR REVIEW PROTECTED HEALTH INFORMATION

I, _____ HEREBY AUTHORIZE ALL STAR PEDIATRICS TO:

____ OBTAIN RECORDS
OF PROTECTED HEALTH INFORMATION OF:_____
PATIENT NAME AND DATE OF BIRTH

____ RELEASE COPIES

FROM: NAME OF INDIVIDUAL, HEALTHCARE FACILITY OR AGENCY

_____

_____ _____ _____ _____
Street Address City State Zip

SEND RECORDS TO: NAME OF INDIVIDUAL, HEALTHCARE FACILITY OR AGENCY

_____

_____ _____ _____ _____
Street Address City State Zip

FOR THE PURPOSE OF: ____ CONTINUED TREATMENT ____PERSONAL USE ____ OTHER

DATES OF SERVICE: FROM: _____ TO: _____

PLACE YOUR INITIALS BY EACH ITEM TO BE RELEASED:

____ COMPLETE RECORD ____ ALL DIAGNOSTIC TEST RESULTS (LAB/XRAY/ECT)
OR ____ THERAPY RECORDS ____ SPECIALISTS RECORDS
____ ABSTRACT RECORD (VACCINES, WELL VISITS, GROWTH CHARTS, LAST 4 OFFICE VISITS)

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF ALL MEDICAL RECORDS PERTAINING TO MY CHILD/CHILDREN. I UNDERSTAND THAT THESE RECORDS MAY CONTAIN INFORMATION INCLUDING PROTECTED HEALTH INFORMATION, PSYCHOLOGICAL,PSYCIATRIC SUBSTANCE/ALCOHOL ABUSE, HIV/AIDS TESTING AND OTHER PERSONAL INFORMATION.

_____ _____
Parent/Legal Guardian Signature Date of Authorization

PARENT/LEGAL GUARDIAN PRINTED NAME:_____
ADDRESS:_____
_____
PHONE NUMBER _____

DUE TO THE CONTINUITY OF CARE, WE REPECTFULLY REQUEST THE RECORDS BE RELEASED VIA MAIL OF FAX WITHIN 5 BUSINESS DAYS FROM THE DATE OF THIS REQUEST.

THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING DATE, EVENT OR CONDITION _____/ _____ / _____

IF I FAIL TO SPECIFY AN EXPIRATION DATE, EVENT, OR CONDITION, THIS AUTHORIZATION WILL EXPIRE IN ONE YEAR. I UNDERSTAND THAT THIS AUTHORIZATION IS REVOCABLE UPON WRITTEN NOTICE TO THE OFFICE WHERE THE ORIGINAL AUTHORIZATION WAS OBTAINED.