Beaches Pediatrics, PA
Rebecca Cooper, MD., J.D.
YOUR FAMILY IS OUR FAMILY

MEDICAL RELEASE FORMS

Date: _____

1. I hereby authorize the release of ALL my medical records from:

   _____
   Name of physician or practice name

   _____
   fax number and phone number of practice/physician

and request that they be transferred to:

_____*BEACHES PEDIATRICS, PA*
333 4TH AVENUE NORTH
JACKSONVILLE BEACH, FL, 32250
904-246-8684 (fax) 904-246-6878

_____*BEACHES PEDIATRICS, PA*
13820 OLD ST AUGUSTINE RD #101
JACKSONVILLE, FL 32258
904-260-2565 (fax) 904-246-6878

2. I hereby authorize the physicians at Beaches Pediatrics to discuss and share my child's information with the following individuals:

_____

3. I hereby authorize the following individuals to discuss and share my child's information with the physicians at Beaches Pediatrics:

_____

I understand that any disclosure of information carries with it the possibility for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact my physician's office manager. I understand that I have the right to revoke this authorization at any time except to the extent action has been taken prior to revocation. I understand that if I revoke this authorization, I must do so in writing to the address of the releasing institution. I release the provider, and the person's associated with this company from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein, I understand I do not have to sign this authorization in order to obtain health care treatment. I understand that any medical information released may include details of my or my children's medical evaluation and treatment. As part of the medical record, the following information will be released unless stricken: sexual abuse information, drug and alcohol abuse information, psychiatric information and AIDS/HIV information.

Below are my children's names and DOB

Name: _____ DOB:_____

Name: _____ DOB: _____

Name: _____ DOB:_____

_____ _____
Parent's Name Parent's Signature

_____
Address, City, State, Zip Code and Phone Number