Dr. Bou PEDIATRICS
www.drbou.com

Dr. Bou Pediatrics- Wesley Chapel
20713 Center Oak Dr.
Tampa, FL 33647
P: 813-948-8814; F: 813-907-8070

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name:_____
Last First M/I

Date of Birth: _____ Social Security Number: _____
Month/Day/Year

Address: _____ Phone Number: (_____)_____
Street (include PO BOX/APT)

_____ Athena Account Number: _____
City State Zip Office Use Only

Description of Information to be Released:
Treatment Date(s): ALL AVAILABLE

□ **PERTINENT SUMMARY (includes all * items)**

□*Face Sheet	□*Consult	□*Radiology Report	□ Office Visit Note	□ Radiology Images
□*Discharge Summary	□ *Pathology Report	□*Lab Report	□ Physical Therapy	[X] Entire Chart
□*History & Physical	□*Operative Report	□*EKG Report	□ Other _____	

Please Release Medical Information to the Following Recipient:
Name of Person or Organization: DOCTOR BOU PEDIATRICS (WESLEY CHAPEL) Phone: 813-948-8814
Address: 20713 Center Oak Drive Fax: 813-907-8070
Tampa, FL 33647 Appt Date/Time: _____

The purpose of the authorized use or disclosure of the information described above is as follows:

[X] Continuity of Care	□ Attorney Inquiry	□ Social Security	□ Employer Request
□ Insurance Claim	□ At the patient's request	□ Worker's Comp.	□ Other : _____

*I the undersigned, authorize_____ (Disclosing Institution) and its employees to release information from my medical records as described above. I understand and acknowledge that the medical record may contain information regarding psychiatric disorders, Human Immune Virus (HIV) test results, Acquired Immune Deficiency Syndrome (AIDS), AIDS-related conditions, alcohol, and/or drug dependence/abuse and authorize the release of the same pursuant to this authorization. I also understand that information used or disclosed according to this authorization may be subject to re-disclosure by the recipient and may no longer be protected**. My failure to thoroughly complete and sign this authorization may result in my information not being released.***

This authorization for release of information is valid for 60 days from the date of signature, unless revoked by me through written notice, provided the said notice of revocation is received prior to release of the information. If you need assistance in revoking this authorization please contact the Health Information Management-Medical Records Department directly.

I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my failure to sign this authorization.

X _____ _____/_____/_____
Signature of patient (or patient's representative)** Date Signed

_____
Relationship of personal representative to patient and scope of authority (guardian, parent, durable power of attorney)

**If other than patient's signature, a copy of legal documents MUST accompany the authorization when presented, the exception is a parent of minor under 18 years of age.