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Orlando Pediatrics
SAMER KHAZNADAR MD

800 N. Rose Ave.
Kissimmee, FL 34741
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## Authorization for the Copy, Release or Inspection of Protected Health Information

**Patient Name:** _____ **DOB:** _____ **Phone:** _____
**Address:** _____
**City:** _____ **State:** _____ **Zip Code:** _____

By signing this authorization, I authorize the party listed below to use and/or disclose certain protected Patient Health Information (PHI) about me/my child.

This authorization permits:

**Provider Name:** _____ **Phone:** _____
**Address:** _____**Fax:** _____

## [ ] to release to: [ ] to obtain from:

**Orlando Pediatrics 800 N. Rose Ave. Phone: (407) 483-7925**
**SamerKhaznadar, MD Kisssimmee, FL 34741Fax: (407) 483-7924**

The Following:
[ ] Hospital records including history, physical, and discharge summaries from the dates:

_____to _____.

[ ] Emergency room notes from the period: _____ to _____.

[ ] Diagnositic tests and labs.

[ ] Immunization records (Please fax immunization records. All other requested records may be sent by mail.)

[ ] Office notes from the period: _____ to _____.

[ ] Complete medical record.

Purpose of Disclosure:

| | | |
|---|---|---|
| [ ] Referral to Specialist | [ ] Insurance | [ ] Legal Investigation |
| [ ] Change of Physician | [ ] Worker's Comp. | [ ] Disability Determination/SSI |
| [ ] Continuing Care | [ ] Personal | [ ] Other, please specify: _____ |

Information to be excluded/not released:
[ ] Mental health records[ ] HIV Testing[ ] Drug/Alcohol treatment[ ] Sexual assault/Victimization records
[ ] Other, please specify: _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification, but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____ _____
Signature of Parent/Legal Guardian Relation to Patient Date