PEDIATRIC EPILEPSY & NEUROLOGY SPECIALISTS

Authorization for Release of Information

Patient Name: _____ DOB: _____

Request and give my permission to release my child's medical records from the following medical clinic:

Pediatric Epilepsy & Neurology Specialists
508 S. Habana Ave. Suite 340, Tampa, FL 33609
813-873-7367 ~ Fax: 813-875-9722

The medical records as listed above are to be released to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Comments: _____

_____

Pediatric Epilepsy and Neurology Specialists

5. I understand that this consent includes and authorizes access to all of the identified patient's health information. I also understand that this consent is voluntary and not required to receive services.
6. I understand that this consent is revocable upon notice. I also understand that the consent shall remain in effect until revoked in writing.
7. I understand that this consent authorizes release of psychiatric information, if present.
8. I understand that this consent authorizes release of AIDS/ARC information and/or HIV antibody testing/results, if present.

_____ _____
Signature of Patient/Legal Guardian Date

_____ _____
Print Name Relationship

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