Sadiq Mandani, MD
Ramya Pottimuyapu, MD
Cristy Summers, ARNP
870 Clark St., Ste 1000
Oviedo, FL 32765
Ph 407-977-1135 Fax 407-977-9946

Authorization to request health information

I, _____ the parent or guardian of:

Patient Name: _____ Date of Birth: _____

Hereby authorize **Oviedo Children's Health Center** to:

Request records from:

Physician and/or Practice Name: _____
Address: _____

Phone_____ Fax _____

The following type of medical information: (list dates and tests if specifics needed)

- **o** Complete Medical Records _____
- **o** Laboratory Reports _____
- **o** Radiology Reports _____
- **o** Other (Please Specify) _____

medical information, information regarding any sexually transmitted disease, psychiatric treatment, drug and/or alcohol abuse, HIV testing, ARC and/or AIDS information in my records will be released. If you prefer certain medical information not to be released, please contact the appropriate office staff.

This information for which I am authorizing disclosure will be used for the following purpose:

□Continuity of care □Relocation □Insurance □Transfer of care
□Other (Please specify) _____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must provide the revocation in writing to Oviedo Children's Health Center. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that this authorization will expire 90 days from the date of the signature or when acted upon, whichever event occurs first. I understand that any disclosure of information carries with it the potential of an unauthorized redisclosure, and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact Oviedo Children's Health Center Privacy Officer at 407-977-1135. I hereby release to the forwarding addressee, its employees and appointed representatives from all liability that may arise from the release of information as I have directed. I understand that signing this form is voluntary and of my own free will. I understand that Oviedo Children's Health CEnter will not condition treatment, payment, enrollment in any health plans or my eligibility for benefits if I decide not to sign this form. This authorization for the release of the above indicated documents may be revoked at any time, upon notification of the patient or representative assigned above. Revocation has no effect on prior action taken under direction of the signed dated consent for release.

_____ _____
Signature of Patient/ Legal Representative Date

_____
Parent/Legal guardian contact phone number