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# Hillsborough Pediatric & Adolescent Medicine, PLLC

## RECORDS REQUEST

Patient Name(s): \_\_\_\_\_

Date(s) of Birth: \_\_\_\_\_

Patient Contact Phone Number: \_\_\_\_\_

**I authorize Hillsborough Pediatric & Adolescent Medicine, PLLC to RELEASE or OBTAIN (please circle one) information to/from:**

Name of Provider of Facility: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Fax number: \_\_\_\_\_

**Information to be released/obtained (check appropriate boxes):**

Comprehensive report     Office visit notes     Laboratory reports     Immunization records

Radiology Reports     Operative reports/Procedure notes     Other: \_\_\_\_\_

**I understand that my protected health information may be re-disclosed by the person/class of persons/facility receiving it, and would at that time no longer be protected by federal privacy regulations.**

**I understand that I may revoke this authorization at any time by notifying Hillsborough Pediatrics in writing of my desire to revoke it. However, I understand that any action already taken on reliance of this authorization cannot be reversed and my revocation will not affect those actions. I understand that Hillsborough Pediatrics may not condition treatment of me upon whether or not I sign the authorization.**

**This authorization expires on \_\_\_\_\_ or sooner if at any time I should revoke it, or upon the occurrence of the following expiration event for which this disclosure was authorized.**

Printed Name of Legal Representative: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Signature of Patient or Legal Representative: \_\_\_\_\_ Date: \_\_\_\_\_