PEDIATRIC ASSOCIATES OF JULINGTON CREEK
1631 Racetrack Rd. Suite 101
Jacksonville, FL.32259
MARY ANN GARCIA M.D
VICTOR LUZ M.D
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I do hereby give my consent to: _____
_____
_____
_____

to disclose and give copies of information to:

Pediatric Associates of Julington Creek
1631 Racetrack Rd. Suite 101
Jacksonville, Florida 32259
Phone: (904)230-7977 Fax: (904)230-7979

Including the diagnosis and records of any treatment or examination rendered to my child

_____ _____
Patient Name (print) Date of Birth

Specifically, the following reports will be included:

___Progress Notes __X-ray reports __ Laboratory/ Pathology Reports
___ Consultation Reports ___Immunization Record __Hospital Records
___ Other (specify) _____

___(initials) I ____ DO (or) ____ DO NOT consent to release of information relating to psychiatric or psychological testing or treatment, biofeedback training, alcohol and/or drug abuse diagnoses, prognosis and treatment and/or HIV (AIDS) testing and/or results or such disclosure shall be limited to the following specific types of information:

Purpose of disclosure: ____ Medical Care ____ Other_____

This authorization shall be valid for 365 days from the date of signature. The patient can revoke the authorization in writing at any time prior to the expiration date. The patient agrees that a photocopy of this authorization may be considered valid. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above named facility and its parent company from all liability and damage resulting from the lawful release of my Protected Health Information.

_____ _____
Signature of parent of Legal Guardian Date

_____ _____
Relationship to Patient Witness signature and date