Beachside Pediatric Associates, P.A.
Saving Lives - Making A Difference

HIPPA Authorization of Release of Information

I hereby authorize the disclosure of my or my child's individually identifiable health information as described below. I understand this authorization is voluntary. I also understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the federal privacy regulations.

Patient name: _____ Patient Date of Birth ____/____/_____

Patient name: _____ Patient Date of Birth ____/____/_____

Patient name: _____ Patient Date of Birth ____/____/_____

Healthcare provider for whom we are requesting records -City & State- Phone & Fax

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Please send the requested information to:
Lalitha Vadlamani-Simmers, MD at Beachside Pediatric Associates, PA
490 Hwy 85N, Ste A, Niceville, FL 32578 fax (850) 424-6220

Information Requested:

1. Entire medical record ____ 2. Last 3 years _____ 3. Last 5 years _____ Vaccine Record _____

2. Purpose of disclosing information: Insurance____ Attorney____ Doctor____ Personal____ Moving____

Patients Rights and Signature: I understand that my or my child(s)' records may contain information regarding the diagnosis and treatment of all medical conditions, including such confidential information pertaining to the diagnosis/treatment of conditions such as HIV/AIDS/STIs, drug and/or alcohol abuse and mental health illnesses. I give my specific authorization for these records to be released and I understand that I do not have to sign this authorization at any time to receive medical treatment at the practice indicated above. I understand that I can revoke this authorization at any time. This signed authorization is valid for 5 years from the date of signature unless another duration is specified in writing on this form.

_____ _____ _____
name of patient/patient's representative signature of patient/patient's rep. date