Sunshine Pediatrics of St. Augustine

Shelby H. Cline, MD
101 Whitehall Dr., Suite 108
St. Augustine, FL 32086
Phone: (904) 615-1794 Fax: (904) 341-5552

Patient Name: _____ Date of Birth: _____
Address: _____
City/State/Zip: _____Phone#:_____

◯ I authorize Sunshine Pediatrics to release my medical information to :

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____ _____
Phone# Fax #

OR

◯ I authorize Sunshine Pediatrics to obtain my medical information from:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code_

_____ _____
Phone# Fax#

Purpose for this request: (check one)
☐ Continuation of Care ☐ Attorney/Legal ☐ Insurance ☐ Other: _____

Specific documents to be Released:
☐ All Documents ☐ AIDS/HIV ☐ Immunizations ☐ Psychiatric
☐ Drug/Alcohol ☐ Progress Notes ☐ Other: _____

Expiration (If left blank, expires one year from date below):
This authorization expires _____.
This authorization applies to the records of the treatment received on or prior to the date of this authorization.

I understand that:

- Authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment, payment or eligibility for benefits.
- The information in my/my child's health record may contain information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.
- There may be a charge for copies of my/my child's medical record.
- I may cancel this authorization at any time by submitting a written request to the address above.

Signature of Patient/Parent/Legal Guardian _____Date_____

Printed Name_____ Relationship_____