KIDS HEALTH ALLIANCE
CONSENT FORM

Please list all physicians (s) names and fax numbers the records to be released from:

Physician name:	Address:	Phone #:	Fax#:

Please mail records if more than 10 pages

Patient name: _____ Date of birth: _____

I. My Authorization

You may use or disclose the following health care information (check all that applies):

- ☐ All my health information maintained by the above-named practice
- ☐ My health information relating to the following treatment or condition: _____
- ☐ My health information for the date(s): _____
- ☐ Other: _____

You may disclose this health information to: **Kids Health Alliance, PA**
2650 NW 2nd St, Ocala FL 34475
Phone: 352-237-5400 Fax: 352-236-3091

Reason(s) for this authorization (check all that apply):

- ☐ At my request to provide continuity of care
- ☐ Other (specify) _____
- ☐ This authorization ends on (date) _____
- ☐ Indefinitely

II. My Rights

I understand that the release or transfer of the information specified to any person or entity not specified above is prohibited. An additional written consent must be completed for any proposed new use of the information or for its transfer to another person. I release and hold harmless Kids Health Alliance, PA, and the physicians of the medical practice from all liability that may arise from complying with this authorization.

☐ I understand that the medial records may contain medical and administrative information from other health care providers.

☐ I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization.

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☐ I understand that authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

x_____ _____
Patient or legally authorized individual signature Date

x_____ _____
Printed Name if signed on behalf of the patient Relationship