Children's Endocrine & Diabetes Care, Inc.
1447 Medical Park Blvd. Suite 104
Wellington, FL 33414
Off: 561-792-1525
Fax: 561-792-1521

****Request to Release, Copy, or Inspect Protected Health Information****

Patient Name: _____ **Date of Birth:** _____

Patient Address: _____

_____ **Phone #:**_____

For Record Release or Copy: By signing this authorization, I authorize the party listed below to use and/ or disclose certain protected health information (PHI) about me/my child.

This authorization permits:

to use or disclose to

_____ Provider's Name	_____ Provider's Name
_____ Street Address	_____ Street Address
_____ City, State ZIP	_____ City, State ZIP
_____ Phone #	_____ Phone #
_____ Fax #	_____ Fax #

Information to be Released/Copied: ( ) All pertinent medical records ( ) Progress Notes ( ) Lab Results ( ) Bone age ( ) History & Physical ( ) MRI results ( ) Ultrasound results ( ) CT results ( ) Other_____

Information to be excluded: ( ) Mental Health Records ( ) Drug/Alcohol Treatment ( ) HIV testing ( ) Sexual Assault/ Victimization Records

Reason for Record Release or Copy: ( ) Personal Copy **{See Below/ Charges Apply}** ( ) Over age 21 ( ) Insurance Change ( ) Moving/ Changing Providers ( ) Referral to Specialist ( ) Unhappy with Practice **(please state why):**_____ ( ) Other_____

For Patient or Guardian Inspection/ Copy Requests: ( ) Check Here
I understand and agree that I am financially responsible for the following fees associated with my request: copying charges, including the cost of supplies and labor, and postage related to the production of my information. I understand that the charge for this service is: **$1.00 per page for the first 25 pages, then $.25 for each page thereafter.**

_____ Signature of Patient or Legal Guardian	_____ Date*
_____ Print Name of Patient or Legal Guardian	***Inspection requests are valid on the date of signature only** ***Release /Copy requests expire 30days from signature date**