



Lynn Keefe, MD

pediatrics

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 Niceville, FL 32578
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS AND PROTECTED HEALTH INFORMATION

PATIENT'S NAME	BIRTHDAY	/	/
PATIENT'S NAME	BIRTHDAY	/	/
PATIENT'S NAME	BIRTHDAY	/	/
ADDRESS	PHONE		
	EMAIL		

I hereby authorize _____ to release all information from the patient's
Physician Name/Hospital Name/Clinic Name
 medical records during the period _____ to _____ to include:

- MEDICAL TRANSCRIPTS LAB REPORTS X-RAY REPORTS

Release records to **Lynn Keefe, MD Pediatrics**

2600 Partin Drive N Bldg. 300, Ste. 320, Niceville, FL 32578.

Please do not fax if greater than 20 pages; please send on disc or via USPS.

_____	/	/
Patient/Authorized Guardian Signature	Date	
_____	/	/
Witness	Date	

Authorization can be revoked in writing,
 but not retroactive to disclosure of information made in good faith.
 Purpose of these records is for continuing care of patient.

*This authorization will automatically expire one year from the above date, if not specified otherwise.