Lynn Keefe, MD
pediatrics

2600 Partin Drive N Bldg. 300, Ste. 320
Niceville, FL 32578
850.279.6260 Fax: 850.279.6760

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.

_____ / /
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.