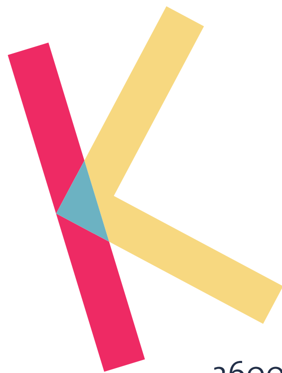

Lynn Keefe, MD
pediatrics

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 / /
ADDRESS	PHONE
	EMAIL

I hereby authorize **Lynn Keefe, MD Pediatrics** to release all information from the patient's medical records during the period ____________________ to ____________________ to include:

☐ MEDICAL TRANSCRIPTS ☐ LAB REPORTS ☐ X-RAY REPORTS

Release records to:

Physician Name/Hospital Name/Clinic Name

Physical Address

Office phone number Fax

/ /

Patient/Authorized Guardian Signature Date

/ /

Witness Date

Authorization can be revoked in writing,

but not retroactive to disclose 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.