Gulf Coast Pediatric Care LLC
1285 Spring Street, Suite A
Gulfport, MS 39507
228-284-2002

AUTHORIZATION TO RELEASE INFORMATION

1. Patient Identification:

Name: (Last, First, MI)		
Street Address:		
City:	State:	Zip Code:
Birth Date:	Phone Number:	

2. Information to be release: (check all that apply)
   - ☐ Educational Records
   - ☐ Discharge Summary (Inpatient dates: _____to _____)
   - ☐ Medication Record
   - ☐ Other: _____

3. Purpose of this request: _____

4. Duration: This authorization shall become effective immediately and remain in effect until (date) _____.
5. My rights:
   - I may revoke or change this authorization at any time in writing to Gulf Coast Pediatric Care, LLC, except where a disclosure has already been made in reliance on my prior authorization.
   - I have a right to receive a copy of this authorization.
   - I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
   - If the person or facility receiving this information is not covered by privacy regulation, the information stated above could be re-disclosed.

I have read and understand this information:

Signature: _____ Date: _____

Witness: _____ Date: _____