Coastal Kids Endocrinology & Weight Management, LLC
400 Gulf Breeze Pkwy, Suite 300 · Gulf Breeze, FL 32561
Ph: 850- 203- 6654 Fax: 850-999-7669

07/2026

AUTHORIZATION to OBTAIN, RELEASE or REVIEW PROTECTED HEALTH INFORMATION (PHI)

Name: _____ DOB: _____

I hereby consent Coastal Kids Endocrinology and Weight Management employees' access to my child's personal health information (PHI), including laboratory tests, imaging results and progress notes, from any lab/hospital. I authorize the release of the records to Coastal Kids Endocrinology and Weight Management for review and acknowledge that I am parent/caregiver/legal guardian of the patient above. I understand that my information will be protected under applicable privacy laws and will only be used for personal health care purposes.

Information to **be obtained FROM**:
Name of organization/doctor's name:
Phone #:
Fax#:

Name: _____ Date: _____

Signature: _____ Relationship to patient:_____

I hereby grant Coastal Kids Endocrinology and Weight Management and it's employees permission to release my child's personal health information (PHI) to:

Information to **be released TO**:
Name of organization/doctor's name:
Phone #:
Fax#:

Information to be released (check all that apply):

- ☐ Recent office visit note(s) from primary care
- ☐ Recent labs reports
- ☐ Recent imaging/radiology reports (such as bone age, ultrasound or MRI or CT)
- ☐ Growth curve, including both height/length and weight
- ☐ Prior endocrine notes if pertinent/available

Authorization & Acknowledgment:

I understand this authorization is voluntary and may be revoked at any time by written notice, except to the extend action has already been taken in reliance on it. I understand that once the records are disclosed, they may no longer be protected by federal privacy laws. Unless otherwise specified, this authorization will remain valid for 12 months from the date of signature. I understand that medical providers are allowed by Florida law (#456.057, F.S.) to charge reasonable fees for copying and mailing records.

I consent for the practice to obtain and review my/my child medical records. By obtaining and reviewing my/my child's medical records, the provider will be able to make better decisions when it comes to my/my child's medical care.

Name: _____ Date: _____

Signature: _____ Relationship to patient: _____