North Florida Pediatrics

Authorization for Use and Disclosure of Protected Health Information

Print name		Date of Birth
Address	City	State Zip
Telephone #	Last 4 digits of SSN (optional)	Medical Record # (if known)

By signing this form, I authorize North Florida Pediatrics to disclose protected health information to:

Person or Facility		☐ Check here if same as patient
Address	City	State Zip
Telephone #	Fax #	Attention:

Patient Information to be disclosed. ***Check each category of information to be released.***

Specific Dates Needed:

☐ History and Physical ☐ Immunizations ☐ Discharge Summary ☐ Problem List

☐ Medication List ☐ Allergy List ☐ Doctor's Orders ☐ Entire Record

☐ Other (specify) _____

Purpose of Request: ☐ Treatment/Continued Care ☐ Payment/Billing ☐ Personal Use ☐ Other _____

Specially Protected Records

I understand that if my health record contains information in reference to diagnosis, treatment, and/or examination related to mental health, substance and/or alcohol abuse, HIV/AIDS, and sexually transmissible diseases. I agree to its release.

☐ I agree ☐ I do not agree, please specify _____

I understand that I have a right to inspect and to obtain a copy of mt records. I hereby release and discharge North Florida Pediatrics, and all persons acting under its permission and authority from any liability that may arise from the release of patient information as I have directed. I understand that state law prohibits the re-disclosureof the information disclosed to the persons/entitles listed above without my further authorization, but that North Florida Pediatrics cannot guarantee that the recipient(s) of the information will not re-disclose this information contrary to such prohibition.

I understand that this authorization will remain in effect for one (1) year or until I revoke it in writing. I understand that I have the right to revoke this authorization but only to the extent that North Florida Pediatrics has not already relied on this authorization. I may revoke this authorization by providing a written statement to North Florida Pediatrics at the facility address or fax number about. If I refuse to consent, my refusal will not affect my enrollment in a health plan, eligibilty for benefits, my eligiblity to receive care or affect the quality of care I receive.

I understand that I will be charged a fee of up to $0.10 per page, for a total no greater than $6.50. This fee is waived for copies provided to a health care provider for continuing medical treatment. I understand that this fee is within the limits allowable by Florida law. Additional fees may apply for radiological images. Charges as follow: *$0.10 per page (Up to $6.50)* **x _____ = Total Charged $_____**

Signature of Patient/patient representative: _____ Date:_____

Complete following section only if person making the request is NOT the patient.

Name of Requestor:_____ Relationship to Patient ☐ Parent or Legal Guardian ☐ Other _____

Checked ID? ☐ Yes ☐ No Method of Payment: ☐ Credit Card ☐ Cash Initials: _____