

Authorization for Use and Disclosure of Protected Health Information

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	Print name				Date of Bir	th.		
Last 4 digits of SSN (optional) Medical Record # (if known)	Print name				Date of Bill	LII		
By signing this form, I authorize North Florida Pediatrics to disclose protected health information to: Person or Facility	Address	City			State		Zip	
Person or Facility	Telephone #	Last 4 digits o	Last 4 digits of SSN (optional)			Medical Record # (if known)		
Address		a Pediatrics to disclose	orotected h	nealth infor	mation to	1		
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)	Person or Facility				Check	here if same a	ıs patient	
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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 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 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-disclosured 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 the facility address or fax number about. If I refuse to consent, my refusal will not affect my enrollment in a health plan, eligibility for benefits, my eligibility 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 limit	Telephone #	Fax #		Attention:				
History and Physical Immunizations Discharge Summary Problem List Medication List Allergy List Doctor's Orders Entire Record Entire Record Dother (specify) Purpose of Request: Treatment/Continued Care Payment/Billing Personal Use Other Specially Protected Records 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 Inderstand 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-disclosure of the information disclosed to the persons/entitles itsed above without my further authorization, but that North Florida Pediatrics cannot guarantee that the recipient(s) of the information will not re-disclosure this information contrary to such prohibition. Inderstand 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 thorfaliforida Pediatrics has not already relied on this authorization. I may revoke this authorization by providing a written statement to North Florida Pediatrics and 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	Patient Information to be disclosed. Check e	ach category of informa	tion to be	released.				
Medication List	Specific Dates Needed:							
Other (specify)	History and Physical Immuniz	☐ Immunizations ☐ Discharge Summa		e Summary		Problen	n List	
Purpose of Request: Treatment/Continued Care Payment/Billing Personal Use Other Specially Protected Records	Medication List Allergy L	ist	Doctor's	Orders		Entire F	Record	
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Complete following section only if person making the request is NOT the patient. Name of Requestor: Parent or Legal Guardian Other	health, substance and/or alcohol a I agree I do not agree, please specify I understand that I have a right to inspect and to obtain a copy permission and authority from any liability that may arise from the information disclosed to the persons/entitles listed above to information will not re-disclose this information contrary to such I understand that this authorization will remain in effect for on the extent that North Florida Pediatrics has not already relied to Pediatrics at the facility address or fax number about. If I refuse 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 pag continuing medical treatment. I understand that this fee is with	of mt records. I hereby release and the release of patient information without my further authorization, chiprohibition. The (1) year or until I revoke it in writion this authorization. I may revoke to consent, my refusal will not a may be, for a total no greater than \$6.50 min the limits allowable by Florida	d discharge Non as I have direct but that North ting. I understate this authorizate ffect my enrollr	rth Florida Pedicted. I understa Florida Pediatri nd that I have to tion by providin nent in a health	iatrics, and all particles, and that state latics cannot guar the right to revige a written state plan, eligibilty	persons acting using probability the antee that the rocke this authority tement to North of or benefits, managed the care proven	under its e re-disclosureof recipient(s) of the szation but only to h Florida ny eligiblity to	
Complete following section only if person making the request is NOT the patient. Name of Requestor: Parent or Legal Guardian Other								
Name of Requestor: Relationship to Patient Parent or Legal Guardian Other		auest is NOT the natient				Date:		
Parent or Legal Guardian U Other		· · · · · · · · · · · · · · · · · · ·						
		Payment:				er		

Last Revision: 2/21/17 MC Form/Document Number: MR5-H