FLORIDA CHILD NEUROLOGY

A Division of Florida Pediatric Associates, LLC

Authorization for Use/Disclosure of Protected Health Information

PATIENT NAME: ____ DOB: ____________________

****MUST PROVIDE NAME, ADDRESS, PHONE, AND FAX NUMBER (MISSING INFORMATION WILL DELAY YOUR REQUEST). ****

PERSON(S)/ORGANIZATION TO PROVIDE INFORMATION: SENDER INFORMATION:	PERSON(S)/ORGANIZATION TO RECEIVE INFORMATION: RECEIVER INFORMATION:
____________________________________	____________________________________
____________________________________	____________________________________
____________________________________	____________________________________

INFORMATION TO BE RELEASED:

(Check ALL that apply)	Date(s)
__ History & Physical Exam	____________
__ Office Visits	____________
__ Lab Reports	____________
__ X-Ray Reports	____________
__ Patient Medical Photos	____________
Other ________________	____________

I specifically authorize the release of information relating to:

__ Substance Abuse (including alcohol/drug use)

__ Mental Health (including psychotherapy notes)

__ HIV related information (including AIDS related testing

__ Genetic Testing

X ______________________________

signature

PURPOSE OF DISCLOSURE:

__ Changing Physicians __ Consult/Second Opinion __ Continuing Care __ Legal __ Other ____________________

This authorization will expire on ____________ (NOTE: If left blank, it will expire 12 months from date signed).

I understand that I may:

1. Request a copy of this authorization.
2. Revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. Refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits; however the office has the right to deny the above request.
4. Inspect or obtain a copy of any information used or disclosed under this agreement and I am aware that I must request to do so with the completion of the appropriate form.

I understand that if the organization that receives the information is not healthcare provider, plan or business associates (of a provider or plan) covered by federal privacy regulations, the information described above may be re-disclosure by the recipient and no longer be protected by Federal privacy regulations. Additionally, the authorized provider would not be held responsible for any re-disclosures by the person or organization that receives the information.

____________________________	_________	OR	____________________________	_________
SIGNATURE OF PATIENT	DATE		PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON	DATE

RELATIONSHIP TO PATIENT: ________________________

OFFICIAL USE ONLY: INFORMATION RELEASED BY: ________________ DATE RELEASED: __________