Authorization to Obtain, Release or Copy Protected Health Information (PHI)

Patient Name: _____ D.O.B: _____ Phone_____

Address_____
City State Zip Code

By signing this authorization, I authorize the party listed below to use and/or disclose certain protected health information (PHI) about me/my child.

THIS AUTHORIZATION PERMITS:

Provider/Persons Name: _____ Phone: _____

Address: _____ Fax: _____

City: _____ State: _____Zip Code: _____

TO OBTAIN FROM:_____

TO DISCLOSE TO: _____

TOTS&TEENS PEDIATRICS
933 Brown Chapel Road St. Cloud FL 34769
TEL: (407)-593-2883
FAX (407)-593-2884

The following information:

- ○ Hospital records including *History & Physicals and discharge summaries*
- ○ Emergency Room Notes
- ○ Diagnostic Tests and Labs
- ○ Immunization Record
- ○ Office Notes
- ○ Complete Medical Record From the dates: _____to _____

PURPOSE OF THE DISCLOSURE:

___ Referral to Specialist

___ Change Physician ___ Insurance ___ Other: _____

INFORMATION TO BE EXCLUDED, NOT RELEASED:

___ Mental Health Records ___ Drug alcohol Treatment

___ HIV Testing ___ Sexual Assault/Victimization Records

___ Other: _____

I hereby authorize **disclosure of the health information** for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____ _____

Signature of Parent/Legal Guardian Relation to the Patient Date