North Florida Pediatric Associates
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Authorization to Disclose Protected Health Information

Patient Name: _____ Date of Birth: _____
(Last, First, Middle) (MM/DD/YYYY)

Telephone Number: _____

Person or Entity to Receive Information:	Person or Entity to Disclose Information:
Name/Organization: _____	Name/Organization: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Phone: _____ Fax: _____	Phone: _____ Fax: _____

Purpose of Disclosure

___Changing PCP & Discontinuing Care at this Office
___Leaving Town & Transferring Records to New Physician
___Personal Reasons
___Attorney
___Insurance
___Other: _____

Specific Information to be Disclosed

___Complete Medical Records
___Immunization Records
___Mental Health/Counseling
___Lab Reports
___Financial
___Other: _____

* **I understand that** once my records have been transferred to another local Primary Care Physician, NFPA has released all care permanently.
* **I understand that** the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and/or treatment for alcohol or drug abuse. I agree to such release.
* **I understand that** once information is disclosed, the information is subject to redisclosure and may no longer be protected by federal privacy regulations.
* **I understand that** I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records supervisor. I understand the revocation will not apply to information already released in response to this authorization. I understand that the revocation will not apply to my health plan when the law provides my plan with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in **six (6)** months from the date signed below.
* **I understand that** authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure treatment. I understand I may inspect or copy the information used or disclosed as provided in **CFR164.524**. If I have questions about disclosure of my health information, I can contact the Privacy Officer.

_____ _____
Parent/Guardian Signature Date

_____
Parent/Guardian Name (Please Print)