North Florida Pediatric Associates

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Authorization to Disclose Protected Health Information

You must complete all required fields. We will not honor your request unless all required fields are completed. *(* signifies a required field)*

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

***Telephone #:** _____

***From:**
Name (*coming from*): North Florida Pediatrics
Address: 3606 Maclay Blvd Ste 102
City: Tallahassee State: Fl Zip: 32312
Telephone: 850-877-1162 Fax:850-671-5009

***To:**
Name (*going to*): _____
Address: _____
City: _____State_____ Zip_____
Telephone: _____Fax:_____

TYPE AND AMOUNT OF INFORMATION TO BE USED OR DISCLOSED IS AS FOLLOWS: (*Include dates when appropriate*)

***From**: (DATE) _____ **To:** (DATE) _____
( ) Medical Records ( ) Immunization Records ( ) Mental Health/ Counseling ( ) HIV/AIDS ( ) Financial

***PURPOSE OF DISCLOSURE:** ( ) Changing PCP & discontinuing care at this office
( ) Leaving town & transferring records to new physician ( ) Attorney ( ) Personal reasons ( ) Insurance
( ) Office of Disability Determination ( ) Other: _____

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 in order 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.

***Signature of Patient or Legal Representative**	***Relationship**	***Date**
_____	_____	_____