CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ____ DOB: ____________________________

I authorize North Florida Pediatric Associates to disclose the following protected health information about my child to the following family member(s) or person(s) involved in my child's care or payment for my child's care:

**Provide the names of authorized people, OTHER than parents. If no one else is authorized to receive information, please mark "No One". **

Name:	Relationship to Patient	Phone Number:

Check all that may apply:

____ All of my child's medical information.
_____Information necessary to schedule appointment.
_____Lab or test results.
_____Information necessary to provide, call in or pick up prescriptions for my child.
_____ Information necessary to help my child's family member(s) take care of my child.
_____ Information necessary to allow my child's family member(s) to pick up or arrange for medical equipment to be provided for my child.
_____ Information necessary to bill for or submit claims for care provided to my child to government or private insurance payors.

My consent will remain in effect as long as my child is a patient with North Florida Pediatric Assoc. unless I notify NFPA in writing with changes.

Parent/Legal Guardian Name: ____
(Please Print)

Parent/Legal Guardian Signature: ____ Date: _________________

Relationship to Patient: ____