Authorization for Lawrence Bergman, MD, LLC to obtain Protected Health Information

(PHI) – Medical Release Form

I, _____ (parent/guardian) hereby authorize

_____ (previous pediatric practice)

Address: _____
Telephone: _____ Fax: _____

to disclose all medical records of my child, _____, to Lawrence Bergman, MD, LLC, including psychological/psychiatric conditions, drug/alcohol information and HIV/AIDS information.

This PHI is being used or disclosed to carry out treatment, payment and/or health care operations of Lawrence Bergman, MD, LLC.

I understand that I have the right to revoke this authorization in writing, at any time by sending written notification to Lawrence Bergman, MD, LLC in care of the Privacy Contact person. I understand that a revocation is not effective to the extent that Lawrence Bergman, MD, LLC has relied on the use or disclosure of the PHI for my child.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Lawrence Bergman, MD, LLC will not condition my child's treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits whether I provide authorization or the requested use or disclosure.

I understand that I am solely responsible for any fees incurred in copying and/or obtaining these records and in no way are these fees the responsibility of Lawrence Bergman, MD, LLC.

I understand I have the right to refuse to sign this authorization.

_____ (Signature of parent/guardian) _____ (Today's Date)

_____ (Printed name of parent/guardian)

_____ (Printed name of child) _____ (Child's Date of Birth)

Please mail these records to: Lawrence Bergman, MD, LLC
10115 W Forest Hill Blvd. Suite 303
Wellington, Florida 33414
561-798-5565 (Phone)
561-461-6287 (Fax)