AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT INFORMATION:

_____ _____

Name Date of Birth

_____

Street Address

_____ _____

Email Address Phone Number

RELEASE MEDICAL RECORDS FROM:

_____

Name

_____

Phone Number

_____

Street Address

_____

Email Address / Fax Number

RELEASE MEDICAL RECORDS TO:

_____

Name

_____

Phone Number

_____

Street Address

_____

Email Address / Fax Number

DATES OF SERVICE: (REQUIRED) _____/_____/_____ To _____/_____/_____

Medical Records To Be Released: (REQUIRED - Check Items Below)

☐ Office Visits - i.e. progress notes, medication list, medical history ☐ Echoes - i.e. cardiology

☐ Laboratory Reports - i.e. bloodwork, cultures ☐ Immunization Records ☐ Referral - specialists

☐ Radiology Reports - i.e. x-rays ☐ Growth Charts ☐ Itemized Bills

☐ Other (please specify): _____

Special Authorization To Disclose Super Confidential Information:

ALCOHOL/DRUG/INFECTIOUS DISEASE/MENTAL HEALTH RECORDS are protected by Federal Regulation 42 CFR, Part 2. Release of such records requires specific consent. I hereby grant such specific consent as initialed below. **I UNDERSTAND** that these records are protected under federal and state law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of alcohol or substance abuse, sexually transmitted diseases, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection.

AS PART OF THE MEDICAL RECORDS CHECKED ABOVE, THE FOLLOWING INFORMATION WILL BE RELEASED UNLESS CHECKED:

☐ HIV/AIDS related information and/or records ☐ Mental Health information and/or records

☐ Sexually transmitted diseases ☐ Drug/alcohol diagnosis, treatment or referral information

SIGNATURE: _____ **DATE**: _____

Patient or legal representative

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Purpose of Disclosure: (REQUIRED)

☐ Personal Copy ☐ Disability Determination ☐ Insurance Purposes ☐ Legal Matter

☐ Transfer of Care (Specify Reason): ☐ Moved ☐ Insurance Change ☐ Graduated to Adult PCP

_____

_____

Other (Please explain):_____

Right to Revoke Authorization

I may revoke this authorization at any time, in writing, before the information has been released. I further understand that I have a right to receive a copy of this authorization upon request. I hereby release **The Carithers Pediatric Group** from any and all legal liability that may arise from the release of this information to the party named above.

Authorization & Signature:

I hereby authorize the use of disclosure of my child's or my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization. I further understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information could potentially be redisclosed and may no longer be protected by federal privacy regulations. Therefore, I release **The Carithers Pediatric Group** from all liability arising from this disclosure of my health information.

I understand and agree that I am financially resposible for the following fees associated with my request: copying charges and postage related to the production of my information. *For patients and governmental entities:* 1.00 per page for the first 25 pages and 25¢ per page for each page in excess of the first 25 pages. *For other entities:* up to $1.00 per page for each page copied, in accordance with Florida Administration Code 64B8-10.003.

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Printed Name of Patient: _____ Date: _____

Patient Signature: _____

Printed Name of Parent, Guardian or Legal Representative: _____

Parent, Guardian or Legal Representative Signature: _____

Relationship to Patient: _____ Records are needed by: _____ (date)

Send by: ☐ Fax_____ (Patient must initial approval) ☐ Mail ☐ Patient will pick up ☐ Electronic format if EMR