Authorization for Use or Disclosure of Protected Health Information

Name of Patient _____
Date of Birth _____ **SS#**_____ **Acct. #** _____
Daytime Phone # _____ **Evening Phone #**_____
Address _____
City _____ **State** _____ **Zip Code** _____

I herby authorize ***Children's Medical Center*** to disclose my protected health information as indicated below to:

Name _____
Daytime Phone #_____ **Fax #** _____
Address _____
City _____ **State** _____ **Zip Code** _____

Information to be released:
From & To Dates _____

- ○ History & physical exam _____
- ○ Lab report _____
- ○ X-ray report _____
- ○ Consultation report _____
- ○ Other _____

Purpose of Disclosure:

- ○ Changing physicians
- ○ Second Opinion
- ○ Continuing Care
- ○ Legal
- ○ At my (patient) request
- ○ Insurance
- ○ Workers' Compensation
- ○ School
- ○ Other _____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disability and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

- ○ Substance Abuse (including alcohol/drug abuse)
- ○ Mental Health
- ○ Psychotherapy Notes
- ○ HIV related information (including AIDS related testing)

X _____ _____
Signature of Patient or Legal Guardian Date

1. I understand that this authorization will expire two years from my last date of service visit. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying ***Children's Medical Centers*** Privacy Officer at the addresses indicated below, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken reliance upon it.

Children's Medical Center
4651 Sheridan Street, Ste 270, Hollywood, FL 33021 12251 Taft Street, Ste 201, Pembroke Pines, FL 33026
20170 Pines Blvd., Ste 203, Pembroke Pines, FL 33029

3. I understand that the information used or disclose pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that my refusal to sign this authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
6. I understand that I will get a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____ **OR** _____ _____
Signature of Patient **Date** **Parent/Legal Guardian/Authorized Person** **Date**

_____
Relationship to Patient

_____ _____
Records Received By **Date**