Authorization to Obtain, Release or Copy Protected Health Information (PHI)

Patient Name: _____ D.O.B: _____ Phone_____

Address_____
City State Zip Code

By signing this authorization, I authorize the party listed below to use and/or disclose certain protected health information (PHI) about me/my child.

THIS AUTHORIZATION PERMITS:

Provider/Persons Name: _____ Phone: _____
Address: _____ Fax: _____
City: _____ State: _____Zip Code: _____

TO OBTAIN FROM:_____

TO DISCLOSE TO: _____ **TOTS&TEENS PEDIATRICS**
4691 OLD CANOE CREEK RD ST. CLOUD FL 34769
TEL: (407)-593-2883 FAX (407)-593-2884

The following information:

- Hospital records including *History & Physicals and discharge summaries*
- Emergency Room Notes
- Diagnostic Tests and Labs
- Immunization Record
- Office Notes
- Complete Medical Record From the dates: _____to _____

PURPOSE OF THE DISCLOSURE:

___ Referral to Specialist
___ Change Physician ___ Insurance ___ Other: _____

INFORMATION TO BE EXCLUDED, NOT RELEASED:

___ Mental Health Records ___ Drug alcohol Treatment
___ HIV Testing ___ Sexual Assault/Victimization Records
___ Other: _____

I hereby authorize **disclosure of the health information** for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not affect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____ _____
Signature of Parent/Legal Guardian Relation to the Patient Date