Acute Care Pediatrics

Compassionate care close to home

Authorization for Use and Disclosure of Protected Health Information

Date Processed by Medical Records: _____

Patient Name:	Date of Birth:	Telephone #:
Address:	City: State:	Zip:

By signing this form, I authorize Acute Care Pediatrics to disclose protected health information to:

Person or Facility	☐ Check here if same as patient
Address:	City: State: Zip:
Telephone #: Fax #:	Attention:

Patient Information to be disclosed. ***Check each category of information to be released.***

Specific time period from: _____Until: _____

Items Requested:	☐ Problem List		☐ Medication List	☐ Immunizations List
	☐ Discharge Summary		☐ Doctor's Orders	☐ Allergy List
	☐ History and Physical		☐ Entire Record	☐ Other:
Purpose of Request:	☐ Treatment/Continued Care		☐ Personal Use	☐ Other:
Method of Delivery:	☐ Pick-Up	☐ Faxed	☐ Mailed	☐ Other:
Format:	☐ Paper	☐ CD	☐ USB	☐ Other:

Sensitive Protected Health Information: I understand that if my health record contains information regarding the diagnosis, treatment and/or examination of mental health, substance and/or alcohol abuse, HIV/AIDS, and sexually transmitted disease, I must specifically authorize the release of this information. By initialing here, I **agree** to the release of my sensitive protected health information. _____**Initial** (If you choose not to release this information, please do not initial, and we will exclude the above-mentioned information from this release.)

- I understand that I have the right to inspect and to obtain a copy of my records. I hereby release and discharge North Florida Pediatrics, and all persons acting under its permission and authority from any liability that may arise from the release of patient information as I have directed. I understand that state law prohibits the re-disclosure of the information disclosed to the persons/entitles listed above without my further authorization, but that North Florida Pediatrics cannot guarantee that the recipient(s) of the information will not re-disclose this information contrary to such prohibition.
- I understand that this authorization will remain in effect for one (1) year or until I revoke it in writing. I understand that I have the right to revoke this authorization but only to the extent that Acute Care Pediatrics has not already relied on this authorization. I may revoke this authorization by providing a written statement to Acute Care Pediatrics by mail or fax. If I refuse to consent, my refusal will not affect my enrollment in a health plan, eligibility for benefits, my eligibility to receive care, or affect the quality of care I receive.
- Hard Copies shall be charged at $0.10 per page, up to a total of $6.50.
- For reproducing specific types of reports, they will be charged at the actual cost of the reproduction, including supplies and labor associated with the request.
- If the patient prefers medical records to be on a USB or CD, Acute Care Pediatrics must provide the flash drive or CD with a cost of $6.50.
- You may request that the records be e-mailed to you free of charge, with the understanding that you assume the risks associated with transmitting your information through the internet.
- You may receive a written summary or your personal health information. The cost will be $6.50.

Signature of Patient/ Patient Representative:	Date:

Complete the following section only if person making the request is NOT the patient.

Name of Requestor:	Relationship to Patient ☐ Parent or Legal Guardian ☐ Other_____