**Authorization for Release of Health**

**Information Pursuant to HIPAA**

**Patient’s Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MI\_\_\_**

Date of Birth: \_\_\_\_\_\_/\_\_\_/\_\_\_\_\_\_\_\_\_\_

Address (including City/State/Zip):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­\_­­­­­­­

I authorize the release of information specified below to the organization, agency, or individual named on this request. This release may may not include information concerning treatment of mental illness, alcohol/drug abuse.

**Release information from: Release information to:**

|  |  |
| --- | --- |
| Pediatric Partners of Zephyrhills 6712 Dairy Rd Zephyrhills, FL 33542Phone: 813-782-6064 Fax: 813-782-0984 | Name/Facility:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City/State/Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pick up Fax Mail  |

Specific information to be released:

 Medical Record from \_\_\_/\_\_\_/\_\_\_\_\_\_ to \_\_\_/\_\_\_/\_\_\_\_\_\_

 Entire Medical Record (including but not limited to histories, office notes, immunization records, test/imaging results, consults, and records sent by you to other health care providers)

 Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for Release:

|  |  |
| --- | --- |
|  Changing doctors Ongoing care Filing lawsuit Other (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  Copies for personal use: I understand that I am responsible for payment of a Medical Records fee at the time I pick up my records. **The fee for my records is $\_\_\_\_\_\_\_\_\_\_\_\_\_** |

I understand that authorization for disclosure of this health information is voluntary and I can refuse to sign this authorization. The above named health care provider cannot condition treatment, payment, enrollment, or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I have the right to revoke the authorization at any time by writing to the health care provider listed above. I understand that I may revoke the authorization, except to the extent that action has already been taken based on this authorization.

Without my previous written revocation, this authorization will automatically expire:

 On \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (date supplied by patient);

 180 days from the date of my signature.

A copy of this authorization with my signature thereon may be utilized with the same effectiveness as an original.

All items on this form have been completed and my questions about this form have been answered. In addition, if needed, I can request a copy of this form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Representative authorized by law Date