Island Coast Pediatrics

Patient Authorization to Use or Disclose Protected Health Information

For info disclosed to third parties, not involved in routine care or financial dealings and, for HIV/Mental Health Information

I, (print name)_____, understand **Island Coast Pediatrics** is authorized by me to use or disclose my child's protected health information for a purpose other than treatment, payment, or health care operations. This form may also authorize the release of mental health records or HIV sensitive information, if specifically noted. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of Island Coast Pediatrics, or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Patient Name: _____Date of Birth: _____

Description of the information to be used or disclosed *(check all that apply)*:

[ ] The patient's entire medical record, (**NOTE: This requires an explanation**).
_____

_____

[ ] Medical Data/Information as related to:
[ ] Specific condition(s): _____Date of Service:_____
[ ] Financial _____Date of Service:_____
[ ] Specific medication(s): _____Date of Service:_____

[ ] Other: _____

HIV:_____ Mental Health Notes_____ **Signature Required_____**
(HIV and Mental Health notes require separate signature.)

Name(s) or class of persons, including address, authorized by this form to use and disclose the patient's protected health information:
Attorney or Other Recipient: _____
_____
Address: _____

Suite/Box_____City_____State_____Zip_____

Contact Phone:_____Fax:_____

No other address or fax number is permitted by this authorization.

Purpose(s) of the information:
_____

_____(See Page Two)

The patient understands that Island Coast Pediatrics may receive financial gain as a result of disclosing this information due to the normal and routine fee charged for copying of records. (Island Coast Pediatrics does not charge for first time requests or immunization records.)

[ ] Other:_____

The patient has a right to revoke this authorization in writing, if applicable. In order for the revocation of this authorization to be effective, Island Coast Pediatrics must receive the revocation in writing. The revocation must include:

- The patient's name and address.
- The recipients of the protected health information according to this authorization.
- The patient's reason for desiring a revocation of this authorization.
- The date of the revocation, and the patient's/guardian's signature.

Island Coast Pediatrics will accept written revocations of this authorization addressed to: Island Coast Pediatrics, Attn: Privacy Officer, 16450 S. Tamiami Trail, Unit 8, Ft. Myers, Fl 33908

This authorization shall expire on **_____(Actual date required).** After this date, Island Coast Pediatrics can no longer use or disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

_____ _____

Patient or Guardian's Signature Date

FOR OFFICE USE ONLY

Obtained from website

Records given/sent by:_____ on_____.

Request **added to the patient's medical record** by:_____on_____.

Revised: 06/14/05