## Authorization for the copy, Release inspection of protected Health Information

Patient Name: _____ D.O.B: _____ Home 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 Name:** _____ Phone: _____

Address: _____ Fax: _____

City: _____ Sate: _____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:**

- o Hospital records including *History & Physicals and discharge summaries*
- o Emergency Room Notes
- o Diagnostic Tests and Labs
- o Immunization Record
- o Office Notes
- o 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