Florida Pediatric Associates, LLC Authorization for Use/Disclosure of Protected Health Information

PATIENT NAME:	DOB;
PERSON(S)/ORGANIZATION AUTHORIZED TO PROPERTIES. Pediatric Neurology Associates, PL - 625 6th Avenue S, Stee	VIDE THE INFORMATION (include phone/address): 405 St.Petersburg, FL 33701 P: 727 498-8994 F: 727 498-8982
PERSON(S)/ORGANIZATION AUTHORIZED TO RECE	EIVE THE INFORMATION (include phone/address:
(Check ALL that apply) Date(s)	I specifically authorize the release of information relating to: Substance Abuse (including alcohol/drug use)
History & Physical Exam Office Visits	Mental Health (including psychotherapy notes)
Lab Reports	HIV related information (including AIDS related testing
X-Ray Reports	Genetic Testing
Other PURPOSE OF DISCLOSURE:	Xsignature
Changing Physicians Consult/Second Opinion Legal Other	
This authorization will expire on (NOTE	: If left blank, it will expire 12 months from date signed).
I understand that I may:	
 Request a copy of this authorization. Revoke this authorization at any time by notifying to the date notified except to the extent action has a 	the providing organization in writing, and it will be effective
•	al will not affect my ability to obtain treatment, payment or my
4. Inspect or obtain a copy of any information used or request to do so with the completion of the appropr	disclosed under this agreement and I am aware that I must riate form.
disclosure by the recipient and no longer be protected be provider would not be held responsible for any re-disclinformation.	vacy regulations, the information described above may be re- by Federal privacy regulations. Additionally, the authorized osures by the person or organization that receives the
SIGNATURE OF PATIENT DATE	OR PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE
OFFICIAL USE ONLY:	
INFORMATION RELEASED BY:	DATE RELEASED: