# HIPAA AUTHORIZATION TO RELEASE RECORDS FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____ am the personal representative of
Name of parent or legal guardian

_____ _____/_____/_____
Patient's name DOB

I hereby authorize Children's Medical Center to use or disclose the patient's protected health information as described in this authorization.

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***PERSONS/ORGANIZATION AUTHORIZED TO PROVIDE THE INFORMATION:***

*CIRCLE LOCATION BELOW*

## Children's Medical Center

***Palm Harbor Office***
**31860 US Hwy 19 N**
**Palm Harbor, FL 34680**
**Phone: 727-787-6335**
**Fax: 727-489-2519**

***Trinity Office***
**10537 State Rd 54**
**New Port Richey, FL 34655**
**Phone: 727-376-8404**
**Fax 727-674-2181**

***Westchase Office***
**12780 Race Track Rd, Ste 305**
**Tampa, FL 33626**
**Phone: 813-891-6501**
**Fax: 813-403-5210**

***Lutz Office***
**23026 State Rd 54**
**Lutz, FL 33549**
**Phone: 813-751-3131**
**Fax: 813-948-1774**

***AUTHORIZED TO RECEIVE THE INFORMATION:**

_____

PHONE: (_____)_____ FAX: (_____)_____

***SPECIFIC DESCRIPTION OF INFORMATION TO BE SENT:** _____

*OR CIRCLE ONE BELOW*

**COMPLETE RECORDS HOSPITAL/ER RECORDS** _____ **SHOT RECORD**
DATE

**LAST PHYSICAL MEDICATION LIST PROBLEM LIST MOST RECENT LABS MOST RECENT RADIOLOGY**

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**I UNDERSTAND THAT:**

- I may refuse to sign this authorization and that my refusal to sign will not affect my care, treatment, benefits or payments.
- This authorization is not for the use or disclosure of psychotherapy notes.
- I may revoke this authorization at any time before its expiration date by notifying the covered entity in writing, but the revocation will not have any effect on any actions the covered entity took before it received the revocation.
- I may have a copy of this authorization upon request.
- If the disclosure authorized above is not to an entity "covered" under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and the privacy regulations issued thereunder, the information that is used or disclosed pursuant to this authorization may be re-disclosed by the received persons or entity and the information will no longer be protected by the federal privacy regulations, unless such re-disclosure is expressly prohibited by other state or federal law (e.g. state or federal laws regulating disclosure of information about substance abuse, HIV/AIDS, pregnancy or reproductive conditions, genetic testing).

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*PRINTED NAME OF REPRESENTATIVE SIGNING: _____ RELATIONSHIP TO PATIENT: _____

*SIGNATURE: _____ _____
SIGNATURE OF PATIENT (OVER 18 YEARS)/ PARENT/ OR LEGAL GUARDIAN DATE