HIPAA AUTHORIZATION TO OBTAIN 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 North Pinellas Children's Medical Center to use or disclose the patient's protected health information as described in this authorization.

PERSONS/ORGANIZATION AUTHORIZED TO PROVIDE THE INFORMATION:

_____

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

AUTHORIZED TO RECEIVE THE INFORMATION:

CIRCLE LOCATION BELOW

Children's Medical Center

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

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

West Chase Location
12780 Race Track Rd, Ste 305
Tampa, FL 33626
Phone: 813-891-6501
Fax: 813-403-5210

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

SPECIFIC DESCRIPTION OF INFORMATION TO BE RECEIVED: _____

OR CIRCLE ONE BELOW

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

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

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