



**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 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:**

*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

**\* 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

**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).

**\* PRINTED NAME OF REPRESENTATIVE SIGNING:** \_\_\_\_\_ **RELATIONSHIP TO PATIENT:** \_\_\_\_\_

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