Beaches Pediatrics
Beach Location: 333 4th Avenue North, Jacksonville Beach, Florida 32250, (p) 904-246-8684, (f) 904-246-6878
Bartram Location: 13820 Old St. Augustine Road, #101, Jacksonville, Florida 32258, (p) 904-260-2565

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM MEDICAL RECORD

PATIENT INFORMATION

This authorization is for the release of medical information.

PATIENT'S NAME _____
Last **First** **M.I.**

ADDRESS_____

BIRTHDATE _____/_____/_____ **DAYTIME TELEPHONE NUMBER** _____
Month _ **Day** _ **Year**

SOCIAL SECURITY NO. _____

AUTHORIZATION:

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on my signing this authorization except as provided by law.

RELEASE FROM LIABILITY:

I further understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information could potentially be re-disclosed and may no longer be protected by federal privacy regulations. Therefore, I release Beaches Pediatrics from any and all legal liability that may arise from what the party named below does within the PHI.

ORGANIZATION/PERSON RECEIVING AND/OR PROVIDING INFORMATION:

(NAME OF PERSON OR ORGANIZATION RECEIVING INFORMATION)

STREET ADDRESS

CITY **STATE** **ZIP CODE**

INFORMATION TO BE DISCLOSED:

☐ All records (including received consultation reports or third party records)
OR ONLY:
☐ Demographic Information ☐ Lab Reports ☐ Diagnostic Test Reports
☐ Consultant Reports ☐ Other (please specify):_____

Please furnish the information specified above for the following dates: Start Date: _____ End Date: _____

PURPOSE OF DISCLOSURE:

☐ Second Opinion ☐ Continuing Medical Treatment

☐ Patient Request

☐ Marketing Promotion: I have been informed that Beaches Pediatrics __is __ is not receiving direct or indirect compensation from a third party as a result of disclosing information for this purpose.

☐ Other (please specify): _____

COPYING COSTS:

The charge for copying costs for the medical records is one dollar ($1.00) per page up to twenty-five (25) pages and twenty-five cents ($0.25) for each page thereafter. **Please allow seven (7) to ten (10) business days for records to be copied.**

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FROM MEDICAL RECORD

SPECIAL AUTHORIZATION TO DISCLOSE SUPER-CONFIDENTIAL INFORMATION:

ALCOHOL/DRUG/INFECTIOUS DISEASE/MENTAL HEALTH RECORDS are protected by Federal Regulations. Release of such records requires specific consent. I hereby grant such specific consent as initialed below. **I UNDERSTAND** that the following records are protected under federal and state law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include diagnosis, prognosis, and treatment for physical and/or mental illness including treatment of alcohol or substance abuse, sexually transmitted diseases, acquired immune deficiency syndrome (AIDS), or human immunodeficiency virus (HIV) infection.

IN ADDITION TO ANY RECORD REQUESTS CHECKED ABOVE, THE FOLLOWING INITIALED RECORD REQUEST(S) MAY BE RELEASED:

_____ HIV/AIDS related information and/or records

_____ Mental Health information and/or records

_____ Sexually transmitted infections

_____ Drug/alcohol diagnosis, treatment or referral information

SIGNATURE: _____ **DATE**: _____
Patient or legal representative

DURATION AND REVOCATION:

This authorization will remain in effect until the patient is no longer a patient of Beaches Pediatrics, unless you specify a different date here:_____

I understand that I may revoke this authorization at any time, in writing to the practice, before the information has been released. I further understand that I have a right to receive a copy of this authorization upon request.

Authorization Copy Received: ☐ **Yes**
☐ **No**

SIGNATURE:

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Date: _____

Patient Signature: _____

Parent, Guardian or Legal Representative Signature:_____

Printed Name of Parent, Guardian or Legal Representative:_____

Relationship to Patient:_____

Legal Representative's Authority to Act for Patient (Power of Attorney, Healthcare Surrogate, etc.): _____

Witness Signature:_____