ORMOND PEDIATRICS PA

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

MEDICAL RECORD #____________________

PRINTED NAME OF PATIENT | PATIEN'TS SOCIAL SECURITY# | DATE OF BIRTH | TODAY'S DATE

STREET ADDRESS | CITY | STATE | ZIP | PHONE NUMBER

***SIGNATURE OF PARENT/LEGAL GUARDIAN | RELATIONSHIP OF REPRESENTATIVE | EXPIRATION DATE OR 90 DAYS

SIGNATURE OF WITNESS

MUST HAVE COMPLETE INFORMATION BEFORE THIS REQUEST CAN BE PROCESSED.

I hereby authorize the use and disclosure (release) of my child's/children's Medical Record Information.

FROM: ORMOND PEDIATRICS, P.A.
Rolando Lozano, M.D.,FAAP
725 W. Granada Blvd. Ste 1
Ormond Beach, FL 32174
Phone 386-673-2770
Fax 386-673-2760

TO: ____________________
____
PHONE # ____________ FAX # ____________

The information to be released includes: ____Entire Medical Record ____ Other: ____________

The Medical Record Information will be used and/or disclosed for the following purposes:

___At the request of the parent/legal guardian ___Changing Primary Care Physician ___ Seeing/Changing Specialist

___Other (write purpose here):____________________

I acknowledge and agree that the term Medical Record Information may include: notes by the provider and other personnel, results, reports, correspondence, x-rays and other diagnostic imaging films, as well as claims, billing and payment information. I expressly authorize the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS related conditions, any drug or alcohol abuse, drug related conditions, alcoholism, and/or psychiatric/psychological conditions unless specifically excluded.

Please exclude the following information, if it is part of my child's Medical Record Information (*Check any or all you want excluded from this authorization for use or disclosure)*.

___Chemical Dependency/Substance Abuse
___ Sexually Transmitted Disease
___ Psychiatric/Psychological conditions
___ Alcohol ___ Drugs ___ N/A

I understand that his Authorization shall remain in effect for a period of 90 days. I further understand that I may revoke this Authorization at any time by notifying Ormond Pediatrics PA in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by Ormond Pediatrics PA before receiving by revocation.

I understand that I have the right to restrict disclosure of my PHI to a health plan, if the disclosure is for payment or healthcare operations and pertains to a healthcare item or service for which I have paid out of pocket in full. I have the right to an accounting of disclosures of any and all breach notifications of my unsecured PHI upon my written request of the SEP Privacy Officer. I also understand I have the option to "opt out" of receiving communications from my provider should I choose to do so as long as I provide them with a request in writing.

PHOTO IDENTIFICATION WILL BE REQUIRED TO PICK UP MEDICAL RECORDS

_____I am designating ____________________to pick up my medical records. I understand my designee or I will need it produce a picture ID in order to obtain the records.

Refusal to sign this authorization in no way affects my treatment, payment or eligibility for benefits. Any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by federal confidentiality rules.