PEDIATRICS IN BREVARD

Authorization for the Release and/or Discussion of Protected Health Information

Patient Name: _____ Date of Birth: _____

Authorization

1. I, _____ hereby authorize: **Pediatrics in Brevard**
   (Name of Patient)

2. To release and/or discuss the following information:
   - ☐ Complete Record
   - ☐ X-Ray Results
   - ☐ Laboratory Results
   - ☐ Outpatient Care
   - ☐ Inpatient Care
   - ☐ Treatment Plan Update
   - ☐ Other: _____

   If my record contains the following information, it is also released if CHECKED in the boxes below:
   - ☐ Substance Abuse
   - ☐ Mental Health Treatment
   - ☐ HIV/STD Testing or Treatment
   - ☐ Pregnancy Testing

3. To _____ Relationship: _____
   (Name of Person)

   Address: _____

   Phone: _____

Signature

I have carefully read and understand the above information and do herein consent to its disclosure. I am aware that information regarding my medical condition will be released to those persons or agencies named above. I understand that in the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun.

This authorization expires _____ 6 months _____ 12 months from today's date, or upon the following specified event: _____.

I authorize the use of a copy of this form for the disclosure of the information described above.

Signature: _____ Date: _____

134 S Woods Drive, Rockledge, FL 32955 321-636-3066 Fax 321-636-2545
1755 W Hibiscus Blvd., Melbourne, FL 32901 321-724-5437 Fax 321-724-5570
699 W Cocoa Beach Cswy Ste. 401, Cocoa Beach, FL 32931 321-784-5437 Fax 321-799-1231
7332 Office Park Place Ste. 103, Viera, FL 32940 321-435-9800 Fax 321-435-9803