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 if 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.

Patient signature: _____ Date: _____

Declination

I, _____ hereby decline the authorization to release
(Name of Patient)

and/or discuss my protected health information with any other individual other than myself.

Patient signature: _____ Date: _____