FLORIDA PEDIATRIC ASSOCIATES, LLC

Eye Physicians of Central Florida

a Division of Florida Pediatric Associates

AUTHORIZATION TO USE & DISCLOSE PROTECTED HEALTH INFORMATION

REQUEST FOR A COPY OF HEALTH CARE INFORMATION

This form is used when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Patient's Full Name:: _____Date of Birth: _____ SSN: _____

Print Patient Address: _____Phone: _____

I. PATIENT RIGHTS

The patient, legal guardian or authorized representative understands and acknowledges that:

- Patients have the right to request that our office provide a copy of health information that is part of the designated record set, as stated in our Notice of Privacy Practices.
- Patients have the right to request a copy of your health information be sent to you, or a third party, in electronic form provided that the record is maintained by us in electronic form.
- Requests may be denied if we determine that the request is false, misleading or unauthorized or if doing so may cause harm to you or to someone else.
- Requests that health information be provided in a certain format may be denied if it is not possible or that it is cost prohibitive, in which case we will contact you to arrange an alternative method.
- Approved requests for records shall be provided within 30 days. You will be notified for any delay.
- It is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.
- Treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.
- Charges may apply in accordance with Florida law.

II. AUTHORIZATION

Purpose of disclosure: ☐- Personal ☐- Continued Care ☐- Other: _____

Authorization applies to the release/disclosure of:

☐- All of my health information (medical record)
☐- My health information relating to the following treatment or condition: _____
☐- My health information covering the period from _____ (date) to _____ (date)
☐- Other: _____

Authorization applies to the release/disclosure of health information to:

☐- Patient/Guardian/Authorized representative ☐- Another health care provider

Print Recipient Name: _____ Phone: _____

Address _____ City _____ State_____ Zip_____

Format requested:

☐- Paper record to be mailed to recipient at above address
☐- Paper record to be faxed to recipient at FAX#_____
☐- Electronic format to be E-mailed to recipient at_____
(I understand that unencrypted email is at risk for unauthorized disclosure and viewing by third parties, and that based on my request I have released the practice from any liability should such a disclosure occur.)
☐- Other:

The undersigned certifies that he/she read and understands this document and has the legal right and is duly authorized to execute this document and accepts its terms as the patient or the parent or legal guardian of the patient.

Indicate if the patient is a minor or unable to sign:

☐- Patient is a minor ☐- Patient is unable to sign because:
_____

Signature of Patient or Authorized Representative: _____Date: _____

Print Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient: ☐- Parent ☐- Legal Guardian ☐- Court Order ☐- Other:

_____