**sAUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS**

# East Lake Pediatrics Phone # 727-372-6760 Fax # 727-372-6808

**Michael Jordan, MD , Rebekah Soto, MD , Cary Aungst, MD, Ellyn Theophilopoulos, MD,**

**Jennifer Leal ARNP, Leah McCormack, ARNP, Rosemarie Rodriguez, ARNP, Jessica Koehler, APRN**

**I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:**

**Name of Patient**_____**D.O.B**_____

**Parents Name** _____**D.O.B**_____

**Name of Physican/Hospital**_____
**(Who we are getting records from)**

**Address** _____**City**_____**State**_____**Zip**_____

**Phone #** _____ **Fax #**_____

**TO:**

**East Lake Pediatrics**
**2137 Little Road**
**Trinity, FL 34655**

**East Lake Pediatrics**
**4150 & 4156 Woodlands Parkway Suit B**
**Palm Harbor, FL 34685**


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**For the Following Purposes**:

| | | | | | |
|---|---|---|---|---|---|
| | Continued Medical Care | | Personal Information | | Legal Follow-up |
| | Disability Insurance | | Other: | | |

**By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information And/or Medical Records, If Such Information And/or Records Exist:**

| | | | | | |
|---|---|---|---|---|---|
| | Please send the entire Medical Record (all information) to the above named recipient. | | | | |
| | Office Notes | | Active Medication List | | Immunization Records |
| | Problem List | | Other Records | | |

**The Following Items Must Be Initialed to Be Included in the Use And/or Disclosure:**

_____ HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases
_____ Mental Health Information and/or Records
_____ Domestic Violence
_____ Genetic Testing Information and/or records
_____ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:_____
_____ Other: _____

**I understand** that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
**I also understand** that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.
**I, further understand** that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.
**Finally, I understand** that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date): _____.

**Print Patient's Name: _____ Date:_____**

**Signature of Patient or Patient's Legal Representative: _____**

**Print Name of Legal Representative (if applicable): _____**

**Relationship to Patient: _____**