AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

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

Michael Jordan, MD, Cary Aungst, MD, Trudi Rash, MD, Chris Smith, MD, Rosana Lastra, MD

Jennifer Leal, APRN, Leah McCormack, APRN, Rosemarie Rodriguez, APRN, Lacey Hodgson, 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: _____