FLORIDA PEDIATRIC ASSOCIATES, LLC

Pediatric Eye Consultants of North Florida
a Division of Florida Pediatric Associates

AUTHORIZATION TO VERBALLY DISCUSS

PATIENT PROTECTED HEALTH CARE INFORMATION

Patient's Name _____ DOB: _____

I give permission to _____ to VERBALLY discuss the following medical and billing information about me (check all that apply)

- Scheduling/Appointment Information
- Medical information, including my symptoms, diagnosis, medications, and treatment plan.
  This does not include information about sexually transmitted disease (STD) testing and treatment, HIV/AIDS testing and treatment, pregnancy testing and treatment, birth control or family planning.
- Lab/test results
- Billing and payment information
- Chemical dependency information, including symptoms, diagnosis, medications and treatment plan.
- Information related to STD testing and treatment and/or HIV testing and treatment.
- Information related to pregnancy testing and treatment, birth control and/or family planning.

The following people are permitted to receive the above information:

NAME	DOB	PHONE #	RELATIONSHIP TO PATIENT

This authorization will expire on _____ **(NOTE: If this line is left blank this authorization will automatically expire in one year)**

I understand that I may:

1. Request a copy of this authorization.
2. Revoke this authorization (except to the extent that action was already taken in accordance of this signed authorization) at any time by notifying this office in writing (the appropriate form can be obtained from office staff).
3. Refuse to sign this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits; however the office has the right to deny the above request.
4. Inspect or obtain a copy of any information used or disclosed under this agreement and I am aware that I must request to do so with the completion of the appropriate form.

I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be re-disclosed and would no longer be protected by these regulations. Additionally, the authorized provider would not be held responsible for any re-disclosures by the person or organization that receives the information.

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:

_____