FLORIDA PEDIATRIC ASSOCIATES, LLC

PEDIATRIC EYE CONSULTANTS OF NORTH FLORIDA

a Division of Florida Pediatric Associates

AUTHORIZATION TO 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.

Patient's Full Name: _____**Date of Birth:** _____ **SSN:** _____

If Adult Patient Please List Previous Last Name: _____

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: Continued Care and/or strabismus or other possible surgical consult.

Authorization applies to the release/disclosure of:

☐ -All outpatient or clinic/office notes pertaining to: **OPHTHALMOLOGY, OPTOMETRY, NEURO, RHEUMATOLOGY OR GENETICS**
☐ - IMAGING RESULTS (MRI, CT SCANS)
☐ - LAB REPORTS (THYROID, AUTOIMMUNE)
☐ - Other: ANY OPERATIVE REPORTS PERTAINING TO THE ABOVE

PERSON/ORGANIZATION AUTHORIZED **TO PROVIDE** THE INFORMATION (**MUST** include address, phone & fax):

_____

Authorization applies to the release of health information to: Pediatric Eye Consultants of N. Florida

Formats accepted (we prefer fax or encrypted email please)

Paper record to be faxed attn. MED REC at FAX# 904-425-9414 (preferred method)
Paper record to be mailed: Pediatric Eye Consultants of N FL Attn: Med Rec 245 Riverside Avenue, Ste 550, Jacksonville, FL 32202
Electronic format to be E-mailed to recipient (encrypted) at info@kidseyesjax.com
(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.)

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 due to: _____

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: (we must receive legal documents supporting this role if other than parent)