Florida Pediatric Associates

Authorization to Verbally Discuss
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
☐ Lab/test results
☐ Billing and payment information
☐ Medical information, including my symptoms, diagnosis, medications, and treatment plan.

To the extent contained in my record, I specifically authorize the release of my/my child's health information, which may include medical, psychological, psychiatric, developmental-alcohol and/or drug abuse, human immunodeficiency virus (HIV) testing or other sexually transmitted disease (STD) information, family planning and birth control, AIDS related information, and genetic information unless I explicitly note otherwise here:
_____

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. My provider may also share my protected health information with family

members and friends that I choose to involve in my care or payment for my care even if not listed above, to the extent allowed by applicable privacy laws.

_____ _____

Patient/Representative Signature Date

_____ _____

(relationship to patient if not patient) Telephone #