# FLORIDA PEDIATRIC ASSOCIATES

## Pediatric Eye Consultants of North Florida,
**a Division of Florida Pediatric Associates**

### CONSENT TO DISCLOSURE OF HEALTH INFORMATION TO FAMILY/FRIENDS

**Patient Name**: _____ **Date of Birth**: _____

To facilitate treatment (or payment for the treatment services received) in relation to the above referenced patient (the "Patient"), I hereby authorize Florida Pediatric Associates, LLC ("FPA") to disclose the Patient's protected health information to the individuals listed below. I understand that This authorization will expire on _____ (NOTE: If this line is left blank this authorization will automatically expire in one year from the date signed).

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

To the extent contained in the Patient's record, I specifically authorize the release of all of health and billing information related to the Patient as needed for treatment, coordination of care, or payment for the services provided to the Patient, which may include (as applicable to the Patient) medical, psychological, psychiatric, developmental-alcohol and/or drug abuse, human immunodeficiency virus (HIV) testing or other sexually transmitted disease (STD) information, reproductive health care information, AIDS information, genetic information, and financial information related to payment for the services the Patient receives, unless otherwise specified here:

Do Not Release: _____

The individuals specified above should be prepared to reasonably verify their identity (for example, by providing identification or the passcode issued to me by this division). I understand that I may request a copy of this form, revoke it at any time (except to the extent that action was already taken in accordance with this signed form) by notifying FPA in writing, and the Patient's treatment is not conditioned on signing this form. I understand that once the individuals listed above receive the Patient's information, it may be re-disclosed, no longer be protected by privacy laws, and that re-disclosure of the Patient's information may occur. I understand that if I choose to involve other friends or family in the Patient's care (such as by having them present at appointments), or payment for the Patient's care, FPA may also share the Patient's information with such other family members and friends so long as I do not object after being provided with the opportunity to do so as long as the information is related to the individual's involvement, to the extent permitted by applicable privacy laws.

**X**_____ _____
Patient/Representative Signature Date

**X**_____
(relationship to patient if not patient)

*If signed in electronic form, I understand that my electronic mark will be given the same legal authority as if signed in paper form.*