jacobsonpediatrics
A division of Florida Pediatric Associates LLC

robyn jacobson, m.d.
3910 northdale boulevard • suite 204 • tampa, florida 33624
(phone) 813.570.6971 • (fax) 813.570.6977

Authorization for Use/Disclosure of Protected Health Information

PATIENT NAME: _____ DOB: _____

PERSON(S)/ORGANIZATION TO PROVIDE INFORMATION:

Name: _____

Address: _____

Phone/Fax: _____

PERSON(S)/ORGANIZATION TO RECEIVE INFORMATION:

Name: **Jacobson Pediatrics**

3910 Northdale Blvd., Suite 204 Tampa,FL 33624
Phone / Fax: P: 813-570-6971 F: 813-570-6977

INFORMATION TO BE RELEASED:

(Check ALL that apply)	Date(s)
____ History & Physical Exam	_____
____ Office Visits	_____
____ Lab Reports	_____
____ X-Ray Reports	_____
____ Patient Medical Photos	_____
____ Immunizations	_____
Other _____	_____

I specifically authorize the release of information relating to:

__ Substance Abuse (including alcohol/drug use)

__ Mental Health (including psychotherapy notes)

__ HIV related information (including AIDS related testing

__ Genetic Testing

X _____
signature

PURPOSE OF DISCLOSURE:

____ Changing Physicians ____ Consult/Second Opinion ____ Continuing Care
____ Legal ____ Other _____

This authorization will expire on _____ (NOTE: If left blank, it will expire 12 months from date signed).

I understand that I may:

1. Request a copy of this authorization.
2. Revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
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 organization that receives the information is not healthcare provider, plan or business associates (of a provider or plan) covered by federal privacy regulations, the information described above may be re-disclosure by the recipient and no longer be protected by Federal privacy regulations. Additionally, the authorized provider would not be held responsible for any re-disclosures by the person or organization that receives the information.

_____ _____ OR _____ _____
PARENT/ LEGAL GUARDIAN/AUTHORIZED PERSON DATE SIGNATURE OF PATIENT DATE

OFFICIAL USE ONLY:

INFORMATION RELEASED BY: _____ DATE RELEASED: _____