1049 Willa Springs Drive, Suite 1031
Winter Springs, FL 32708
Office: 407-335-4760 Fax: 407-388-0104

PLEASE FAX ALL RECORDS IN BATCHES OF 30 PAGES OR LESS

Authorization for **Family First Pediatrics** TO OBTAIN PROTECTED HEALTH INFORMATION

I. Patient's Name: ____________________ DOB: ____________

SSN: ____________________ Phone Number: ____________________

II. I hereby authorize **Family First Pediatrics** to obtain my Protected Health Information from the following organization(s) and/or person(s).

Doctor or Facility Name: ____________________

Address: ____________________

Phone Number: ____________________ Fax Number: ____________________

III. I authorize the following information to be obtained:

Any and all information pertaining to **PEDIATRIC CARE** including current labs, x-ray reports and last office visit.

IV. Purpose of the Requested Disclosure: Please check one and provide the requested information

_________ At request of the patient. _______________
Patient's Initials

_________ Other. Continuing Care of Patient

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter provided to the Privacy Officer. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my Protected Health Information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that **Family First Pediatrics** may not condition treatment on whether I sign this authorization. I further understand that if the person(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by federal privacy regulations.

I agree that a copy of this release or fax of this release shall be as valid as the original release. If I authorize **Family First Pediatrics** to fax information, I realize there are inherent risks in faxing Protected Health Information, I understand a fee will be charged to cover the costs of copying, including the cost of supplies and labor of copying and mailing Protected Health Information released to anyone other than another health care provider. I understand I will get a copy of this form after I sign it.

____________________ ____________
SIGNATURE OF PATIENT, PARENT, LEGAL GUARDIAN DATE

____________________ ____________
PRINTED NAME OF PATIENT RELATIONSHIP TO PATIENT