AUTHORIZATION TO USE & DISCLOSE HEALTH INFORMATION AND MEDICAL RECORD RELEASE

I hereby request and authorize_____
(Print Name of Provider) to release information from my medical record as indicated below to:

Name: North Florida Pediatrics Joseph T. Sherrel MD

Address: 4316 Fifth Avenue City: Marianna State: FL Zip: 32446

Phone: (850)526-5437 Fax: (850)482-6550

Regarding: _____ _____
Patient Name DOB

Consisting of: _____ All Medical Record Information _____ Immunizations
_____ Summary of Office Visits _____ Other
_____

For the purpose of: _____

_____

All information I hereby authorize to be obtained from this AGENCY will be held strictly confidential and cannot be released by the RECIPIENT without my written consent and in accordance to HIPAA privacy regulations. If we are requesting this Authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- -We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- -You may inspect a copy of the protected health information to be used or disclosed;
- -You may refuse to sign this authorization; and
- -We must provide you with a copy of the signed authorization.

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization. Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. HIV/SUBSTANCE ABUSE INFORMATION WILL NOT BE RELEASED WITHOUT A SPECIAL SUBSEQUENT WRITTEN RELEASE. I have reviewed and understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

By: _____ _____
Parent/Legal Guardian/Authorized Person Date

_____ _____
Relationship to Patient Witness