**Authorization for Release of Health Information Pursuant to HIPAA**

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|---|---|
| Patient Name:<br>Social Security Number: | Date: |
| Patient Address: | |

I specifically authorize the release of information specified below to the organization, agency, or individual named on this request. This release ☐ may ☐ may not include information concerning treatment of mental illness, alcohol abuse, and drug abuse.

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| Name and Address of Health Provider or Entity to release this information: |
| Name and Address of person(s), entity, or agency to whom this information will be sent:<br>Pediatric Partners of Zephyrhills Phone: 813-782-6064 Fax: 813-782-0984<br>6712 Dairy Rd<br>Zephyrhills, FL 33542 |

Specific information to be released:

- ☐ Medical Record from (insert date) _____ to (insert date) _____
- ☐ Entire Medical Record, including patient histories, office notes, immunization records, test results, radiology studies, films, referrals, consults, and records sent by you to other health care providers.
- ☐ Other (specify) _____

Reason for Release:

- ☐ Changing doctors
- ☐ Moving
- ☐ Filing lawsuit
- ☐ Claiming Social Security Benefits
- ☐ Copies for personal use
- ☐ Ongoing care
- ☐ Other (specify) _____

I understand that authorization for disclosure of this health information is voluntary and I can refuse to sign this authorization. The above named health care provider cannot condition treatment, payment, enrollment, or eligibility for benefits on the signing of an authorization, except as otherwise permitted by law.

I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I have the right to revoke the authorization at any time by writing to the health care provider listed above. I understand that I may revoke the authorization, except to the extent that action has already been taken based on this authorization.

Without my previous written revocation, this authorization will automatically expire:

- ☐ On _____ (date supplied by patient);
- ☐ 180 days from the date of my signature.

A copy of this authorization with my signature thereon may be utilized with the same effectiveness as an original.

All items on this form have been completed and my questions about this form have been answered. In addition, I have been provided a copy of this form.

_____ _____

Signature of Patient or Representative authorized by law. Date