AUTHORIZATION TO OBTAIN PROTECTED HEALTH INFORMATION

I, _____ (parent/guardian), hereby authorize

_____ (previous pediatrics practice)

located at, _____ (address)

_____ (telephone / fax)

to disclose all medical records of my child to Palm Beach Pediatrics, P.A., including psychological / psychiatric conditions, drug / alcohol information and HIV/AIDS information.

This protected health information (PHI) is being used or disclosed to carry out treatment, payment and /or health care operations of Palm Beach Pediatrics, P.A.

I understand I have right to revoke this authorization, in writing, at any time by sending written notification to Palm Beach Pediatrics, P.A. in care of the privacy contact person at 1920 Palm Beach Lakes Blvd, Suite 201, West Palm Beach, FL 33409. I understand a revocation is not effective to the extent that Palm Beach Pediatrics, P.A. has relied on the use or disclosure of the PHI for my child.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Palm Beach Pediatrics, P.A. will not condition my child's treatment, payment, enrollment (if applicable) in a health plan or eligibility for benefits whether I provide authorization for the requested use or disclosure.

I understand I have the right to refuse to sign this authorization.

_____ Parent / Guardian Signature

_____ Name of Child (please print)

_____ Parent / Guardian Name (please print)

_____ Child's Date of Birth

PLEASE MAIL OR FAX MEDICAL RECORDS TO THE OFFICE CIRCLED BELOW:

Palm Beach Pediatrics, PA
6080 Boynton Beach Blvd
Suite 240
Boynton Beach, FL 33437

Telephone: (561) 509-5009
Fax: (561) 738-0556

Palm Beach Pediatrics, PA
13475 Southern Blvd
Suite 202
Loxahatchee Groves, FL 33470

Telephone: (561) 509-5009
Fax: (561) 798-2733

Palm Beach Pediatrics, PA
4700 N Congress Ave
Suite 201
West Palm Beach, FL 33407

Telephone: (561) 509-5009
Fax: (561) 471-4278