Authorization for PALM BEACH PEDIATRICS, P.A. to obtain Protected Heath Information (PHI)- **Medical Release Form**

I, _____(parent/guardian), hereby authorize

_____(previous pediatrics practice)

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 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. 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.

_____ (Signature of parent/guardian)

_____ (Printed name of parent/guardian)

_____(Printed name child and date of birth)

_____ (Today's date)

PLEASE MAIL RECORDS TO THE OFFICE CIRCLED BELOW:

Palm Beach Pediatrics, PA	Palm Beach Pediatrics, PA	Palm Beach Pediatrics, PA
12955 Palms West Drive	5589 Okeechobee Blvd	8200 S. Jog Road
Suite 100	Suite 102	Suite 101
Loxahatchee, FL 33470	West Palm Beach, FL 33417	Boynton Beach, FL 33472
561-798-2468	561-471-1144	561-509-5009
F: 561-798-2733	F: 561-471-4278	F: 561-738-0556