Pediatric Neurologists of Palm Beach

Comprehensive Epilepsy Center | Childhood Sleep Disorders Clinic
Center for Behavioral & Developmental Neurology | Pediatric Neurology & Epilepsy Research Center

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AUTHORIZATION FOR USE AND/OR DISCLOSURE AND REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION FORM

Patient Name: ____ Date of Birth: ______/______/________
Address: ____ Phone #:____________________ SS#: _______________
City: ____ State: ____________________ Zip Code: __________

The following individual or organization is authorized to make the following disclosure:

Name: ____

Address: ____

City: ____ State: ____________________ Zip Code: _______________

Phone: ____ Fax: ____

Please forward medical records including:

- ☐ **Full Record**
- ☐ **History and Physical**
- ☐ **Consult and Progress Notes**
- ☐ **Discharge Summary**
- ☐ **Emergency Records**
- ☐ **Radiology Reports**
- ☐ **EEG and VEEG Reports**
- ☐ **Laboratory Reports**

Reason for requesting information: Personal ☐ Insurance ☐ Continued Care ☐ Legal ☐

This information may be disclosed to and used by the following individual or organization:

Pediatric Neurologists of Palm Beach
12959 Palms West Drive Suite 120
Loxahatchee, FL 33470
Phone 561-753-8888 Fax 561-795-5004

This release of information is for continuity of care, unless otherwise stated:

Pursuant to Florida law and the Health Insurance Portability and Accountability Act (HIPAA) of 1996 Privacy Rule, the records may be given only to the person designated, and it may be used only for the purpose listed on this form. No information may be re-disclosed to any other person without specific written consent of the undersigned. Charges are in compliance with Florida law. I understand that signing this authorization is voluntary and will not affect my receipt of treatment. I understand that I may revoke this authorization at any time, in writing, to the address listed above provided that the information has not yet been released. This authorization expires in six (6) months unless another date is written here _______________. Pediatric Neurologists of Palm Beach is hereby released from any responsibility for maintaining the confidentiality of the information released to me or parties designated by me in this authorization, such release being made in good faith.

Patient or Authorized Signature: ________________________Date: _________________
Relationship to Patient: _____________________
Witness: ____________________________________ Date: ___________________