AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION 2020

Release of Records TO Lori McAuliffe MD PA

Name of Child: _____
Date of Birth: _____
Address of Child: _____
City, State, Zip: _____

□ I authorize the following individual or organization to disclose the above named individual's health/education/school information as described below:

Previous Physician/Hospital: _____
Address: _____
City, State, Zip: _____
Telephone: _____
FAX: _____

Receiving Party: **Lori McAuliffe MD PA**
405 Pasadena Ave South
St. Petersburg, FL 33707
(727) 345-2212
FAX: (727) 381-3444

To include dates of service from _____ (date) through _____ (date or present)

Duration: This authorization shall become effective immediately and shall remain effective until _____ **(date)** or for one year from the date of signature if no date is entered.

Revocation: I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the disclosing party. Written revocation will be effective upon receipt, but will not apply to information that has already been released in response to this authorization.

Re-disclosure: I understand that health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and it is no longer protected by federal laws and regulations regarding the privacy of protected health information.

Indicate type of information to be disclosed (specify):

□ Complete Medical Record to include problem list, immunization records, growth charts, lab/radiographic test results, letters from specialists and records of all visits

The following highly confidential items must be checked off to be included in this use/disclosure authorization:

□ Psychological/Behavioral or Mental Health Records **□ Drug/alcohol treatment information**
□ Diagnostic/STD Test Results (including HIV and pregnancy)

Reason information is needed: □ Ongoing medical care □ Personal use (there is a fee for personal use copies)
□ Other: _____

Signature of Child's Parent/guardian: _____
Signature of Patient (when 18 or older): _____

Relationship to Child: _____ **Date signed:** _____
Parent/Patient's Phone Number: _____

Please MAIL records over 20 pages to the above address or FAX records less than 20 pages to:
FAX: (727) 381-3444