pediatrix
CARDIOLOGY ASSOCIATES

TAMPA BAY ADULT
CONGENITAL HEART CENTER
pediatrix

AUTHORIZATION FOR OBTAINING AND DISCLOSING PROTECTED HEALTH INFORMATION

Section A: This section must be completed for all Authorizations

Patient's Name:	**Birth Date:**	**Patient's Address:**

Provider's Name: Pediatric Cardiology Associates Tampa Bay Adult Congenital Heart Center	**Recipient's Name:**
Provider's Address: **625 6th Avenue South, Third Floor, Suite 305** **St. Petersburg, Florida 33701**	**Recipient's Address:**

Provider's Phone Number: **877-537-4787**	**Provider's Fax Number** 727-374-9950	**Recipient's Phone Number**	**Recipient's Fax Number**

This authorization will expire on the following: (Fill in the Date or the Event but not both.)
Date: **Event:**

Purpose of disclosure: ☐ Media ☐ Social Media
☐ Other (explain)_____

Description of information to be used or disclosed

Is this request for psychotherapy notes? ☐ Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. ☐ No, then you may check as many items below as you need.

Description:	**Date(s):**	**Description:**	**Date(s):**	**Description:**	**Date(s):**
☐ Intake Form ☐ Chart Notes ☐ Consultation Report ☐ Laboratory Results ☐ Operative Report ☐ Procedure Note		☐ Diagnostic tests ☐ Echo Report ☐ EKG ☐ Stress Test ☐ Special Test/Therapy ☐ Ultrasound Report		☐ Monitoring Report ☐ All PHI in medical record ☐ Itemized bill: ☐ Other: ☐ Other: ☐ Other:	

I understand that:

I may refuse to sign this authorization and that it is strictly voluntary.
My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken in reliance on this authorization prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
If the requester or receiver is not a health plan, health care provider, healthcare clearing house or business associate of such health plan, health care provider or health care clearing house the released information may no longer be protected by federal privacy regulations and may be redisclosed.
I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
I may receive a copy of this form after I sign it.

Section B: The request of PHI is for the purpose of marketing or for the sale of PHI

Will the recipient receive direct/indirect payment in exchange for using/ disclosing this information for marketing? If yes, describe:	☐ Yes ☐ No
Will the recipient receive financial or in-kind compensation in exchange for the sale of this information?	☐ Yes ☐ No

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Patient Representative:	**Date:**
Print Name of Patient's Representative:	**Relationship to Patient:**

Indicate authorized representative's authority to act on the patient's behalf: (circle one)
o Parent/legal guardian o Limited power of attorney
o General power of attorney o Other (Please describe): _____