Pediatric & Congenital Cardiology Associates

an affiliate of MEDNAX

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

_____ _____

Print Name of Patient D.O.B

I authorize the practice to discuss appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial, insurance and billing information with those listed below. I understand that my or my child's healthcare providers will use his/her judgment in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed HIPPA compliant authorization. This permission will be considered on-going until I indicate otherwise in writing.

PHI may be release to the following individuals:

1. _____
2. _____
3. _____
4. _____

THE PRACTICE STAFF HAVE MY PERSMISSION TO LEAVE MESSAGES CONCERNING TREATMENT (i.e., LAB RESULTS) on my: (Please check all boxes that apply)

- ☐ Home Voice Mail or Answering Machine Home Phone Number: _____
- ☐ Cell Phone Cell Phone Number: _____
- ☐ Work Voice Mail Work Phone Number: _____
- ☐ **NO INFORMATION**: I do not authorize the release of any verbal information (other than appointment reminders to the number(s) I have provided).

_____

Print Name of Authorized Representative

_____ _____

Patient/Authorized Representative Signature Date of Signature

Authorized Representative's authority to act on the Patient's behalf:

- ☐ Parent/Legal Guardian
- ☐ Power of Attorney

*Evidence of authority must be provided and on file with the practice.