PEDIATRIX CARDIOLOGY

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION TO FAMILY AND FRIENDS

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 provider 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 HIPAA-compliant authorization. This permission will be considered on-going until I indicate otherwise in writing.

PHI may be released to the following individuals:

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

THE PRACTICE STAFF HAVE MY PERMISSION 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) that I have provided).

_____ _____

Print Name of Patient *Print Name of Authorized Representative

_____ _____

Patient/Authorized Representative Signature Date Signed

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

o Parent/legal guardian o Power of Attorney

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

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGMENT FORM

Our Notice of Privacy Practices ("Notice") provides information about: 1) the privacy rights of our patients; and 2) how we may use and disclose protected health information about our patients.

Federal regulation requires that we give our patients or their authorized representatives our Notice before signing this acknowledgment.

If you have any questions about your rights or our privacy practices, please send an electronic message (e-mail) to **privacy_officer@pediatrix.com** or a letter to:

Privacy Officer
Pediatrix Medical Group, Inc.
1301 Concord Terrace
Sunrise, FL 33323

By signing this form, you are only acknowledging that you have been provided our Notice.

_____ _____
Signature of Patient or Authorized Representative Date

_____ _____
Print Name of Patient Print Name of Authorized Representative

PEDIATRIX MEDICAL GROUP OBSTETRIX MEDICAL GROUP