PEDIATRIX CARDIOLOGY

AUTHORIZATION to RELEASE PROTECTED HEALTH INFORMATION (PHI) 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 (Health Insurance Portability and Accountability Act) authorization. This permission will be considered ongoing until I indicate otherwise in writing.

PHI MAY BE RELEASED TO THE FOLLOWING INDIVIDUALS:

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

___ Yes ____ No The practice staff have my permission to share my or my child's personal health information with family members or others who are in the room with me/us during the appointment.

The practice staff have my permission to leave messages concerning treatment (i.e., Lab Results) on my: (Please check all that apply)

- ☐ Home Voice Mail/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

**Evidence of authority must be provided and on file with the practice; Authorized Representative's authority to act on the patient's behalf:*

☐ *Parent/Legal Guardian* ☐ *Power of Attorney*