

PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION (DISCLOSURE TO PEDIATRIC NEUROPSYCHOLOGY ASSOCIATES PLLC)

Patient Information

Full Name:

Date of Birth:

Home Address:

Home Phone Number:

I Authorize the Release of Information From

Facility/Provider's Full Name:

Address:

Phone Number:

Fax Number:

Email:

Please complete this section with the contact information of the provider or facility sending the records to Pediatric Neuropsychology Associates PLLC.

To Be Released To

Facility/Provider's Full Name: Pediatric Neuropsychology Associates PLLC

Address: 2699 Stirling Rd Suite C306C Ft. Lauderdale, FL 33312

Phone Number: 954-284-0048

Email: admin@pediatricneuropsychologyassociates.com

Purpose of Disclosure

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Disclosure will be limited to the minimum necessary information consistent with the stated purpose, unless full disclosure is expressly authorized. This authorization permits Pediatric Neuropsychology Associates PLLC to disclose my information for the following purposes (Note: "at the request of the patient" is sufficient if the patient is initiating this Authorization)

Please check one or more:

- Continuity of Care (e.g., transfer to another provider, to share my care and treatment records with another health provider)
- A valid court order will be honored as required by law. A subpoena may require additional legal safeguards prior to disclosure.
- Insurance or Disability Claims
- Personal Use
- School or Academic Purposes
- Other (specify):

Expiration of Authorization

This authorization expires:

On This Date: _____

Date Range: From: _____ To: _____

One Year From Signature Date

All dates

Specific Information to be Disclosed

Please check the records you authorize us to release. Each category includes a "catch-all" option for full disclosure of that section. Only records maintained by the releasing provider or facility may be disclosed under this authorization.

Mental Health Records

All Mental Health Records (excluding psychotherapy notes; including all the types of information below)

Intake or Psychological Evaluation
 Psychiatric Evaluation/Medication Management
 Diagnosis & Treatment Plan
 Medication Records
 Psychological Testing Final Report
 Progress Notes or Treatment Summaries
 Discharge Summary
 Behavioral Assessments or Screenings
 Other (specify):

Medical Records

All Medical Records (including all the types of information below)

Clinic Visit Notes
 Emergency Room Report
 Surgical Report (operative, pathology)
 Hospitalization (H&P, Consultations, Test, Surgeries, Discharge)
 Primary Care or Specialist Notes
 X-rays Films or Imaging Studies
 Immunization History
 Medication List
 Lab/Imaging Results
 Test Results (Specify: Lab, X-Ray, EKG, etc.)
 Other (specify):

Educational Records

All Educational Records (including all the types of information below)

Records to Support Academic or Educational Needs
 Psychoeducational or Neurodevelopmental Evaluations
 Disability Documentation (e.g., IEP, 504, ADA)
 School-Related Behavioral or Functional Reports
 Coordination with School or College Services
 Other (specify):

Other Therapy Records

All Therapy Records (including all the types of information below)

Speech-Language Pathology (SLP) Evaluations or Therapy Notes
 Occupational Therapy (OT) Evaluations or Reports
 Physical Therapy (PT) Assessments or Treatment Records
 Applied Behavior Analysis (ABA) or Behavioral Reports
 Developmental or Early Intervention Records
 Other (specify):

Administrative / Other Records

All Administrative or Supportive Records (including all the types of information below)

Billing/Insurance Records
 Records Related to a Specific Injury with the Following Date (e.g., workers' compensation injury)
 Other (specify):

Format of Release

Paper Copies Secure Message Fax Verbal Discussion Email

I understand that Pediatric Neuropsychology Associates PLLC recommends using secure messaging through the EHR for sensitive information. By checking this box, I accept the risk of sending/receiving unencrypted email.

I authorize verbal exchange of relevant information between the parties listed above.

Specific Consent: Authorization for Release of Sensitive Protected Health Information

By checking any of the boxes below, I am specifically authorizing Pediatric Neuropsychology Associates PLLC to use and/or disclose the category of confidential information indicated next to the box, if applicable to this authorization:

Category	Authorized	Initials (required)
Information related to a mental health condition or developmental disability**	Yes No	
Psychotherapy Notes (which are not part of the official medical record)	Yes No	
Information about HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed, or reported, regardless of whether the results of such tests were positive or negative)	Yes No	
Information about Communicable Diseases	Yes No	
Information about Venereal Disease(s)	Yes No	
Information about Substance (i.e., alcohol or drug) Abuse or Treatment	Yes No	
Information about Abuse of an Adult with a Disability	Yes No	
Information about Sexual Assault	Yes No	
Information about Child Abuse and Neglect	Yes No	
Information about Genetic Testing	Yes No	
Information about Domestic Abuse	Yes No	
Reproductive Health Records	Yes No	
Disability Determination Form	Yes No	

These records will not be released unless initialed, even if part of broader categories.

Parent and/or Legal Representative Acknowledgement & Understanding

This authorization is governed by HIPAA and Florida law. You have the right to receive a copy of the information disclosed and to request restrictions on certain disclosures where allowed by law.

I understand that once my provider discloses my health information to Pediatric Neuropsychology Associates PLLC, my provider cannot guarantee that the information will not be redisclosed by the recipient. Pediatric Neuropsychology Associates PLLC will comply with applicable federal and Florida laws regarding the use and disclosure of the information it receives.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from the provider or payment or my eligibility for benefits. If my treatment is for the sole purpose of creating health information for disclosure to Pediatric Neuropsychology Associates PLLC, then the provider may refuse to treat me if I do not sign this Authorization.

I understand that I may change my mind and revoke this authorization in writing at any time by notifying the provider, and changing my mind will not affect my treatment. The revocation will not apply to the extent that any provider has already taken action where it relied on my permission.

I understand that I have the right to inspect or request a copy of the information disclosed.

I have read and understand the terms of this authorization and I have had a chance to ask questions about the use and disclosure of the health information. I authorize the provider to use or disclose my health information in the manner described above.

Electronic Signatures and Records

By signing this form electronically, I agree that my electronic signature and any related electronic records shall have the same legal validity and enforceability as a handwritten signature and paper documents. I acknowledge the use of electronic records for this agreement.

Parent or Legal Representative Consent and Acknowledgment (for Minors or Individuals Lacking Legal Capacity)

I affirm under penalty of perjury that I am legally authorized to sign this authorization. Custody or guardianship documentation may be required.

I have received, read, and understood this Authorization to Disclose Health Information to Pediatric Neuropsychology Associates PLLC. By signing below, I authorize my provider to disclose the health information described in this form and confirm that I am the parent or legal representative of the patient named below and have the legal authority to consent on the patient's behalf. I understand and voluntarily agree to the terms of this authorization.

Printed Name of Patient:

Printed Name of Parent/Legal Representative:

Signature of Parent/Legal Representative:

Relationship to Patient:

Date:

A copy of this signed authorization will be retained in the patient's health records.

For Office Use Only

Date Received:

Received By:

Staff Role:

Filing Method: Paper File Digital File Both

Notes: