

PATIENT AUTHORIZATION TO DISCLOSE HEALTH INFORMATION DISCLOSURE FROM 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: Pediatric Neuropsychology Associates PLLC/Dr. Moshe Maiman

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

Phone Number: 954-284-0048

Email: admin@pediatricneuropsychologyassociates.com

To Be Released To

Facility/Provider's Full Name:

Address:

Phone Number:

Fax Number:

Email:

Purpose of Disclosure

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: authorization applies to all records generated by Pediatric Neuropsychology Associates PLLC.

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 Pediatric Neuropsychology Associates PLLC may be disclosed under this authorization.

Mental Health Records

- All Mental Health Record (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
 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

Verbal disclosures will be limited to the minimum necessary information relevant to the stated purpose of this authorization.

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 about a Mental Illness 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 Pediatric Neuropsychology Associates PLLC discloses my health information to the individual or organization listed in this authorization, that recipient may not be subject to HIPAA or Florida confidentiality laws, and Pediatric Neuropsychology Associates PLLC cannot guarantee that the recipient will not redisclose the information to a third party or as required by law.

I understand that I may refuse to sign this authorization, and my refusal will not affect my ability to receive care, payment, or benefits. However, if my treatment is being provided solely for the purpose of creating information for disclosure (such as an evaluation or report), Pediatric Neuropsychology Associates PLLC may decline to provide services if I do not sign this authorization.

I understand that I may revoke this authorization at any time in writing by notifying Pediatric Neuropsychology Associates PLLC. Revoking it will not apply to any disclosures already made in reliance on this authorization.

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 the opportunity to ask questions. I authorize Pediatric Neuropsychology Associates PLLC to disclose my health information as outlined 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 from Pediatric Neuropsychology Associates PLLC. By signing below, I authorize Pediatric Neuropsychology Associates PLLC 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: