Emergency Contact & Limited Emergency Information Release

Effective Date: December 1, 2025

Practice Information

Pediatric Neuropsychology Associates PLLC
Address: 2699 Stirling Rd Suite C306C
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Legal and Regulatory Foundation

This authorization is provided in accordance with the Health Insurance Portability and Accountability Act (HIPAA), including 45 CFR §164.512 (disclosures to avert a serious threat to health or safety), and applicable Florida law.
This form authorizes limited emergency action and information sharing when necessary to protect the safety and well-being of the patient.

Patient Information

Patient Name:

Date of Birth:

Address:

Parent/Legal Representative Information

Parent/Legal Representative Name (if minor):

Relationship to Patient: ☐ Parent ☐ Legal Representative ☐ Authorized Representative

Address:

Phone Number:

Email Address (optional):

Primary Emergency Contact

Name:

Relationship to Child:

Phone Number(s):

☐ Mobile:

☐ Alternate:

Secondary Emergency Contact (Someone other than the parent/legal representative on this form)

Name:

Relationship to Child:

Phone Number(s):

☐ Mobile:

☐ Alternate:

Authorization for Emergency Action & Information Sharing

If the patient experiences a medical, emotional, behavioral, or other health-related emergency while participating in services at this practice or during practice-related activities, we may need to contact designated individuals and/or share essential health-related information. This may include:

- ☐ Contacting the individuals listed above
- ☐ Contacting emergency contacts without prior notice when immediate action is required
- ☐ Contacting appropriate authorities when required by law to protect the child's safety (e.g., mandated reporting). The provider may disclose information to law enforcement or appropriate authorities when required by law, including mandated reporting of abuse, neglect, or credible threats o
- ☐ Sharing relevant health, personal, or safety-related information with the emergency contacts or other authorized individuals designated on this form
- ☐ Reaching out to appropriate professionals or emergency services for support
- ☐ Taking reasonable and appropriate actions to protect the child's immediate safety and well-being

This consent authorizes the clinician to take reasonable and appropriate actions, consistent with professional and ethical standards, to protect the child's immediate safety and well-being in emergency or time-sensitive situations (e.g., significant emotional distress, medical concerns, or acute behavioral incidents).

The clinician may rely on professional judgment, consistent with ethical standards and applicable law, to determine when emergency disclosure or intervention is necessary.

This form does not replace or substitute for medical consent required by hospitals, emergency departments, or other healthcare facilities.

This authorization does not create a 24/7 monitoring or emergency response obligation. The practice does not provide continuous supervision or crisis services.

Confidentiality and Limited Information Sharing

I understand that information related to the patient's health, behavior, or care is protected under HIPAA and applicable Florida confidentiality laws, including mental health statutes.

I authorize the provider to share only the minimum necessary information in the following situations:

- ☐ Emergency or urgent care situations
- ☐ Coordination with emergency contacts
- ☐ Collaboration with other licensed health professionals or responders as needed

This form does not authorize general release of psychological, neuropsychological, or medical records. A separate written release is required for non-emergency communication with other parties.

Designation as an emergency contact does not grant ongoing or general access to the patient's health records.

Optional Provider Information

Primary Care Physician / Psychiatrist / Other Provider:

Name: _____

Phone: _____

☐ Primary Care ☐ Psychiatrist ☐ Other: _____

Acknowledgment & Signature

- ☐ I confirm the information above is accurate.
- ☐ I authorize this practice to contact the above individuals and act as needed in urgent health-related situations.
- ☐ I understand that this form remains valid until updated or revoked in writing.

Note: Please notify us of any changes in contact information, custody status, or guardianship.

Custody / Authority

☐ I certify that my legal authority to make emergency decisions or receive emergency communications has not been limited or restricted by any court order that I have not provided to the practice.

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 acknowledge that I have received, read, and understood the Emergency Contact and Limited Emergency Information Form of Pediatric Neuropsychology Associates PLLC. By signing below, I confirm that I am the parent or legal representative of the patient named below, that I have the legal authority to act on the patient's behalf with respect to this request, and that I understand and voluntarily agree to the terms of this form.

Printed Name of Patient: _____

Printed Name of Parent/Legal Representative: _____

Signature of Parent/Legal Representative: _____

Relationship to Patient: _____

Date: _____

A copy of this signed form 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: _____