Kids' Medical Care
Diana McLaughlin, MD
2336 Immokalee Road
Naples, FL 34110
239-591-8481
239-596-0212 (FAX)

Name: _____
MR#: _____
DOB: _____
Date: _____

Authorization for Disclosure of Protected Health Information
Patient Request for Access to Protected Health Information

I authorize Kids' Medical Care the use and disclosure of the health information listed below. I authorize Kids' Medical Care to share and receive the health information listed below:

*_____ Any and all medical records (including billing records, alcohol/chemical dependency, mental health information, genetic testing and HIV/AIDS, and sexual transmitted disease related information),

or

*_____ Any and all medical records except: _____

***Reason for Disclosure:** ___ **Transferring** ___ **Moving Away** ___ **Litigation** ___ **Self** ___ **Other** _____

***Information Released From:**

_____
_____
_____
_____
_____

***Information Released To:**

_____
_____
_____
_____
_____

Authorization expiration date: _____ (If left blank, this authorization will expire one year from the signature date.)

I understand that I may inspect or request copies of any information disclosed by this authorization of request for disclosure within 30 days of the receipt of this request.
I understand that production of copies of medical records requires extensive use of resources and you may be charged a fee according to Florida Law.
I understand that Kids' Medical Care is required to maintain records for specified periods of time according to Florida Law. If your request exceeds the required time period the medical records may no longer be available.
I understand that my medical and or billing information could be re-disclosed and are no longer protected by federal health information privacy regulations if the recipient(s) on this form are not required by law to protect the privacy of the information.
I understand that Kids' Medical Care may have the right to deny access to medical information according to Florida Law.
I understand that all medical/ billing records containing information related to **ALCOHOL/SUBSTANCE ABUSE, GENETIC TESTING, MENTAL HEALTH and HIV/AIDS/STD RELATED INFORMATION** will be released unless otherwise indicated above.
I understand that I may revoke this authorization by notifying Kids' Medical Care in writing with the understanding that previously disclosed information would not be subject to my revocation request.
I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for health care services or eligibility for benefits.
I understand that I have a right to request a copy of this form upon signing.

***Signature of Patient:** _____ ***Date:** _____

<u>If parent or legal guardian, sign below and state your relationship to the patient. All legal representatives other than the parents must provide identification and a document of authority.</u>

***Print Name of Parent/Legal Guardian:** _____ ***Date:** _____
Address: _____
_____
Tel. #: _____

***Signature of Parent/ Legal Guardian:** _____ **Relationship:** _____

***MUST BE COMPLETELY FILLED OUT!!**