PEDIATRIX
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PRACTICE LIMITED TO CARDIOVASCULAR DISEASES IN THE FETUS, INFANTS, CHILDREN AND YOUNG ADULTS

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION 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 authorization. This permission will be considered on-going until I indicate otherwise in writing. This revocation will not apply to information that has already been released in response to this authorization. The revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

PHI may be released to the following individuals:

1. ____ 3. ______________________________________

2. ____ 4. ______________________________________

THE PRACTICE HAVE MY PERMISSION TO LEAVE MESSAGES CONCERNING TREATMENT (i.e. LAB RESULTS) on my (Please check all boxes that apply).

- Home Voice mail or 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

Authorized Representative's Authority* to act on the Patient's behalf:

- Parent / Legal guardian
- Power of Attorney

*Evidence of authority must be provided and on file with the practice