





## AUTHORIZATION FOR OBTAINING AND DISCLOSING PROTECTED HEALTH INFORMATION

Section A: This section must be completed for all Authorizations									
Patient's Name:			Birth Date:		Patient's Address:				
Provider's Name:					Recipient's Name: Pediatric Cardiology Associates Tampa Bay Adult Congenital Heart Center Recipient's Address:				
Provider's Address:				625 6th Avenue South, Third Floor, Suite 305 St. Petersburg, Florida 33701					
			Provider's Fax Number		Recipient's Phone Number 877-537-4787		Recipient's Fax Number 727-374-9950		
This authorization will expire on the following: (Fill in the Date or the Event but not both.)  Date: Event:									
Purpose of disclosure:  Media Other (explain) Other (explain)									
Description of information to be used or disclosed									
Is this request for psychotherapy notes? Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. No, then you may check as many items below as you need.									
Description:	Date		Description:		Date(s):	Description:	,	Date(s):	
Intake Form									
If yes, describe: Will the recipient receive financial or in-kind compensation in exchange for the sale of this information?  Yes No									
Section C: Signatures									
I have read the above and authorize the disclosure of the protected health information as stated.									
Signature of Patient/Patient Representative:				Date:					
Print Name of Patient's Representative:				Relationship to Patient:					
Indicate authorized representative's authority to act on the patient's behalf: (circle one) o Parent/legal guardian o Limited power of attorney o General power of attorney o Other (Please describe):									