AUTHORIZATION TO TRANSFER MEDICAL RECORDS TO FSP

(Authorization for the Use and Disclosure of Protected Health Information)

First Steps Pediatrics, PA
5868 Creek Station Drive, Bldg. A
Pensacola, FL 32504
Phone: 850-478-1244 Fax: 850-478-1894

1. I hereby authorize First Steps Pediatrics, PA to use and disclose protected health information from the record(s) of:

Patient's Name:_____
Birth Date:_____
Social Security No.:_____
Home Phone:_____

2. Copies of the following records shall be used and disclosed:

_____ Complete Medical Records; or
_____ Other_____(specifically identify)
_____

3. I understand that copies of the records indicated above will be used by members of First Steps Pediatrics, PA office staff. **Records are to be transferred from:**

Name of Company/ Individual: _____
Address: _____
City/ State/ Zip: _____
Telephone Number: _____

4. I understand that the records used and disclosed pursuant to this authorization form may include information relating to: Human immunodeficiency Virus ("HIV") infection or Acquired Immunodeficiency Syndrome ("AIDS"); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.

5. I understand that to the extent any Recipient of this information, as identified above, is not a "covered entity" under Federal or Florida privacy law, the information may no longer be protected by Federal and Florida privacy law once it is disclosed to the Recipient and, therefore, may be subject to re-disclosure by the Recipient.

6. I understand that the purpose(s) of the requested use and disclosure is (are):

_____At the request of the individual
_____Other:_____

7. I understand that I may revoke this authorization in writing at any time except to the extent that First Steps Pediatrics, PA has already relied on this authorization. I understand that I may revoke this authorization by sending or faxing a written notice to same stating my intent to revoke this authorization. Unless otherwise revoked, I understand that the specific date or event upon which this authorization expires is: _____. (If left blank, the date will be indefinite.)

8. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. First Steps Pediatrics, PA may not condition treatment on my completion of this authorization form. I understand I may inspect a copy of the information to be used or disclosed. **If I have any questions about disclosure of my health information, I can contact First Steps Pediatrics, PA at 850-478-1244.**

Signature of Patient or Legal Guardian _____ Date:_____

Printed Name of Legal Guardian (if any):_____