Send completed form via fax to 813-775-4039 Attn: Medical Records Dept. or via mail to After Hours Pediatrics Attn: Medical Records Dept. 4035 Crescent Park Drive, Riverview, FL 33578

Authorization for Use and/or Disclosure of Protected Health Information

I authorize After Hours Pediatrics ("Provider"), its physicians and/or administrative and clinical staff to use and/or disclose the protected health information of ____ as follows:
[Name of Patient and Date of Birth]

Name and contact information of the person/entity receiving the patient's health information:

____

____

Specific description of the protected health information being used or disclosed to the above recipient (including relevant dates of service, type of service, origin of information and level of detail to be released):

____

____

This protected health information is being used or disclosed for the following purposes (*List specific purposes. "At the request of the individual" is acceptable if the request is made by the patient or the patient's personal representative, and the patient or the personal representative does not state a specific purpose*):

____

____

This authorization shall be effective until _____/_____/_____ (DD/MM/YY) or until the happening of the following event: ____, at which time this authorization expires.

If this authorization is for marketing purposes, will the recipient receive direct or indirect financial compensation from a third party for disclosing the information? Yes No
If yes, describe the direct or indirect financial compensation:

____

____

I understand that, as set forth in the Provider's Notice of Privacy Practices, I have the right to revoke this authorization at any time by delivering written notification to the office staff at this facility or by sending written notification to:

Team Health, Inc.
265 Brookview Centre Way, Suite 400
Knoxville, TN 37919
ATTN: Privacy Officer

I understand that my revocation will only be effective from the date it is received and will not be effective to the extent Provider has already relied on my authorization to use or disclose my protected health information.

I understand that my protected health information used or disclosed pursuant to this authorization may be further disclosed by the recipient and may no longer be protected by federal or state law.

I understand that Provider will not condition my treatment, payment, enrollment or eligibility for benefits (as applicable) on whether I sign this authorization, unless Provider is providing health care services to me for the purpose of creating protected health information for disclosure to a third party.

____ ____
Printed Name of Patient or Personal Representative Date

____
Signature of Patient or Personal Representative

If you have signed this document as the patient's personal representative, please indicate your relationship to the patient and your authority to act for the patient:____

HIPAA Form B