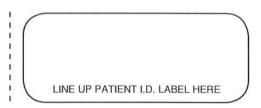




ARNOLD PALMER HOSPITAL FOR CHILDREN *Pediatric Specialty Practice* 83 W. Columbia St., Orlando, FL 32806 tel 321.841.3064 • fax 321.843.6854



AUTHORIZATION TO OBTAIN, RELEASE, OR REVIEW PROTECTED HEALTH INFORMATION

PATIENT AND REQUESTOR INFORMATION:		
Patient Name: Date of Birth / /		
	SSN #:	
Requestor Name: I.D.		
PLEASE SPECIFY IF YOU WANT US TO RELEASE INFORMATION TO, OBTAIN INFORMATION FROM, OR REVIEW INFORMATION		
I hereby allow Arnold Palmer Pediatric Specialty		tices Where Patient Is Seen:
Practices to:	☐ Craniomaxillofacial☐ Endocrine	□ Neurosurgery
Release Information to:	1	□ Neuropsych□ Orthopedics
Name:	☐ Gastroenterology☐ Genetics	☐ Pulmonology
Address:Phone Number:	☐ Infectious Diseases	☐ Physiatry
Fax Number:	Other:	• •
(Orlando Health Policy - We only fax to medical facilities)		_
,	Records to be Release	d
Obtain Information From:	☐ Complete Record	☐ Radiology
Facility Name:	☐ Office Notes	☐ Operative Report
Facility Address:	☐ Test Results	
Facility Phone Number:Facility Fax Number:	Other (specify)	
racility rax Number		
Fax Records to:	Purpose of Release:	
APH Health Info Management: 321.843.6854	☐ Insurance	Continued Treatment
Mail Records to: 83 W. Columbia St., Orlando, FL 32806	☐ Legal Actions	Personal Use
☐ Allow Review of Medical Records:	Other (please specify)	:
Name of Reviewer:		
Relation to Patient:		
This authorization will expire on the following date, event or condition: I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse, and/or AIDS (Acquired Immunode-ficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initialed below or otherwise required by law.		
May NOT include information related to (please initial): HIV/AIDS Mental Health Drug and/or Alcohol Abuse Genetic Counseling/Testing Information		
If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that Orlando Health may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization. I understand that I will receive a signed copy of this form.		
Patient/Legal Representative or Parent/Legal Guardian Sign	nature Date	9
OFFICIAL USE ONLY:		
Name	_Date:	Releasing Information
Number of Pages Copied:		☐ Assisting with Review
☐ I wish to revoke this authorization. Signature:		Date:



ARNOLD PALMER HOSPITAL

For Children

Supported by Arnold Palmer Medical Center Foundation

PEDIATRIC PULMONOLOGY FACULTY PRACTICE

83 W Columbia St. • Orlando, Florida 32806 • 321.841.6350 • Fax: 321.841.6355

Dr. Carlos Sabogal

Dr. Mark Weatherly

Dr. Daniel Garcia

Welcome to Pediatric Pulmonology. We are so happy that you have chosen us to care for your child.

As a new patient, along with this map you will receive a New Patient form to complete. Please bring this **completed** form along with your ID and insurance card to your child's appointment. We ask that you arrive 15 minutes early to your first appointment to allow time for registration.

If you have any questions please feel free to contact our office at 321-841-6350. If you need to have anything faxed to our office the fax number is 321-841-6355.

We look forward to meeting you!

appointment is on

at

with Dr.

