Release of Billing Information

Beachside Pediatric Associates

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Beachside Pediatric Associates, P.A.

Dr. Lalitha Vadlamani-Simmers

saving lives - making a difference

In regards to the patient____DOB________________________

I, or my authorized representative request that health information regarding my care and treatment be released as set forth on this form: in accordance with Florida state law and the HIPPA act of 1996, I understand and agree to the following terms and conditions:

- **Purpose of disclosure:** I authorize beachside Pediatric Associates PA to receive and release my protected health information (PHI) to the following individuals or organizations:
  - **Healthcare providers** involved in my care or treatment.
  - **Insurance companies** or third party payers for reimbursement purposes.
  - **Pharmacies** for prescription medications.
  - **Laboratories** for diagnostic tests.
  - **Referral providers** or specialists involved in my care.
  - **Legal** representatives or other entities as required by law.
- **Types of information:** This authorization includes the release of all PHI related to my medical condition, treatment and for billing purposes.
- **Specific Applications:** I understand these systems are vital to operations and if declined may inhibit my healthcare providers ability to coordinate my care. Systems in use include but are not limited to the following:
  - **FL Shots** the state vaccine registry, to access, and record the immunization status of our patients.
  - **SureScripts**, a prescription system that allows prescriptions and related information to be exchanged between providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taken and/or have taken in the past.
  - **Paper charts, Electronic interface, and Patient portal** are all secure ways to send PHI.
  - **Communications:** If a member of the staff contacts me by **phone call** they should authenticate my identity before speaking about the patient. Since **email** is not considered a secure way to exchange PHI, it should only be used upon my request.
- **Authorization duration:** This authorization remains in effect until revoked by me in writing, except to the extent that action has already been taken in reliance on it.
- **Right to revoke:** I understand that I have the right to revoke this authorization at any time by providing written notice to Beachside Pediatric Associates PA. However, revoking this authorization will not affect any actions already taken in reliance on it.
- **Acknowledgment of Disclosure:** I understand that once my PHI is disclosed, it may no longer be protected by the Health Insurance Portability and Accountability Act (HIPPA) privacy rule.
- **Privacy:** This authorization does not authorize Beachside Pediatric Associates PA to discuss my health information or medical care with anyone other than those permitted under applicable law.

By signing below, I acknowledge that I have read and understood the terms and conditions outlined in this HIPPA release of information and authorize Beachside Pediatric Associates PA to use and disclose my PHI as described.

Name: ____ Relationship ________________________________

Signature:____ Date: _________________________________