Northeast Pediatrics

Bhumi Upadhyay, MD FAAP
431 Southwest Blvd. N
St. Petersburg, FL 33703
727-526-7337 / 727-528-7337 (Fax)

Authorization of Release of Patient – Identifiable Health Information

Patient Name: _____ Patient D.O.B: _____
Patient Name: _____ Patient D.O.B: _____
Patient Name: _____ Patient D.O.B: _____
Patient Name: _____ Patient D.O.B: _____

Phone Number: _____

I authorize the use or disclosure of the above-named individual's health information as described below.
I understand that I have the right to refuse to sign this authorization.

Please Check:
Transferring to our office _____ Obtain
Transferring out of our office _____Release
Reason for Transfer: _____

DOCTOR'S OFFICE/HOSPITAL: _____
ADDRESS: _____
PHONE: _____

Information to be requested:

____COMPLETE MEDICAL RECORDS
____IMMUNIZATION RECORDS
____LABS (To include radiology)

Right to Inspect or Copy the Information to be used or Disclosed
I understand that I have the right to inspect or copy the information used or disclosed in the authorization. I can contact Northeast Pediatrics Privacy officer.
Right to Receive a Copy of this Authorization
I understand that if I agree to sign this authorization, which I am not required to do, I will receive a copy of this signed authorization.
Re-disclosure of Information
I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by confidentiality rules. If I have questions about disclosure of my health information, I can contact Northeast Pediatrics Privacy Officer at 727-526-7337.
Prohibition of Conditions
Northeast Pediatrics may not condition treatment, payment enrollment in a health plan, or eligibility for benefits based on the provision that I authorize this disclosure of my protected health information.
Right to Revoke Authorization
I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must provide the revocation in writing to Northeast Pediatrics. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that if Northeast Pediatrics used this authorization for marketing activities, I will be informed if they receive any direct or indirect remuneration related to the use or disclosure of my protected health information.

Signature of Patient or Parent/Legal Guardian Date