



J.F.K Pediatrics

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Just For Kids Pediatrics

9868 S. SR7 Ste. 305 Boynton Beach, FL 33472

Ph: (561) 369-0111 Fax: (561) 369-4003

Authorization for Release of Information to Family/ Friends

Patient Name: _____ DOB: _____

Many of our patients allow family members and or friends to call and request medical, billing, or scheduling information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical, billing, or scheduling released to anyone such as family or friends (to include spouse, mother, father, grandmother, etc.) you must sign this form. Signing this form will only give information to family/ friends indicated below.

I, _____ whose Date of Birth is _____ authorize J.F.K. Pediatrics/ Just for Kids Pediatrics, Inc. to release my medical, billing, or scheduling information to the following individual(s):

- 1. _____ Relationship: _____
- 2. _____ Relationship: _____
- 3. _____ Relationship: _____

Patient Information:

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health disclosed. If I chose to revoke this authorization, it must be done so in writing.

I understand that the information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

Signature: _____ Date: _____

Witness: _____ Date: _____