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TAMPA, FL 33618

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813-960-3415 PHONE
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Authorization to Telefax or E-mail Medical Records

Full Patient Name: _____ Patient's Birth Date: _____

(First Name)

(Last Name)

Street Address: _____ City, State: _____

Zip: _____ Country: _____

E-mail address: _____

Facsimile Number: _____

Name of Responsible Person Issuing this Authorization: _____

Relationship to Patient: _____

I hereby authorize and direct Wholistic Pediatrics to send all or part of the patient's medical records, lab results, and other protected health information ("Protected Health Information") to me by email or facsimile. This will allow me to receive consultation notes immediately following the consultation so that a medical plan can be promptly instituted.

I acknowledge the following:

1. I have the right to revoke this authorization at any time by sending written notification to you. I understand that the revocation of this authorization is not effective to the extent that you have relied upon it by sending the Protected Health Information prior to receiving my written revocation notice.

2. I understand that any Protected Health Information forwarded to me pursuant to this Authorization may be subject to unauthorized interception and is no longer protected under HIPAA.

3. I acknowledge that you will not condition the patient's care or treatment on whether I sign this Authorization.

Responsible Party Signature: _____

Date: _____