PEDIATRIC EPILEPSY & NEUROLOGY SPECIALISTS

Authorization to Receive Information for Continuation of Care

Patient Name: _____ DOB: _____

For the purpose of continuing care I, _____, authorize Pediatric Epilepsy and Neurology Specialists to receive copies of the above identified patient's medical records including Medical, Psychiatric Care, Drug and Alcohol Abuse and HIV/AIDS/ARC related information.

PEDIATRIC EPILEPSY AND NEUROLOGY SPECIALISTS

1. I understand that this consent includes and authorizes access to all of the identified patient's health information. I also understand that this consent is voluntary and not required to receive services.
2. I understand that this consent is revocable upon notice. I also understand that the consent shall remain in effect until revoked in writing.
3. I understand that this consent authorizes release of psychiatric information, if present.
4. I understand that this consent authorizes release of AIDS/ARC information and/or HIV antibody testing/results, if present.

_____ _____

Signature of Patient/Legal Guardian Date

_____ _____

Print Name Relationship

_____ _____

Witness Date

CONFIDENTIALITY NOTICE

This paper contains information which is confidential or privileged. The information is intended to be for the use of the individual or entity named on this transmission sheet. If you are not the intended recipient, be aware that any disclosure, copying, distribution or use of the contents of this paper is prohibited. If you have received this telecopy in error, please notify us by telephone at 813-873-7367 immediately so that we can arrange for the retrieval of the information at no cost to you.

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