REQUEST FOR CONFIDENTIAL HEALTH INFORMATION

We, the undersigned of Our Kids of Miami-Dade and Monroe, Inc. (authorized representative of patient) request you to release and exchange health & confidential information as described below. We authorize that a photocopy of this release may be considered as valid as the original.

Section A: Client Information:

Client Name:	Biological Mother's Name (if applicable):
Date of Birth:	Social Security Number:

Section B: Name of Organization Releasing Information:

Organization Name:	Address:
Telephone#	Fax#

Section C: This information is to be released to:

Our Kids of Miami-Dade and Monroe, Inc.
401 N.W. 2nd Avenue, South Tower, 10th Floor
ATTN: Nurse Case Management Department
Miami, Florida 33128
Phone: 305-455-6000 • **Fax: 305-455-6201**

I authorize for the records to be released to Our Kids: _X_ Via Fax _X_ Via Mail __ Electronically __ Picked-Up

Section D: The information to be disclosed:

Date(s) of Treatment:

__ Birth records
__ Drug Screen Results
__ Immunization Records
__ All Medical Records
__ All Dental Health Records
__ Newborn Screening Results
__ History & Physical Exam
__ Medical Clearance Exam
__ Child Health Check-Ups
__ Health Insurance Information
__ HIV/AIDS Records
__ Consultations/ Specialists Records
__ All Diagnostic Results
__ All Laboratory Results
__ STD & TB Records
__ Behavioral Health Records
__ Drug/Alcohol Tx Records
__ Other:_______________________________
__ Hospital Records/Discharge Summary
__ Urgent Care/Emergency Records
__ Skilled Nursing Facility Records
__ Psychiatric/Psychological Information
__ Medical History

Section E: The Purpose for Disclosure:

_X_ Legal Purposes _X_ Update Personal Health Record _X_ Sharing with other health care providers as needed
_X_ Continuation and coordination of health care & related services and treatment _X_ Judicial Reviews _X_ Completion of Comprehensive Behavioral Health Assessment
__ Provide ongoing behavioral health assessment, coordination & treatment, psychiatric services, and crisis intervention
__ Other:____

This authorization expires 365 days from the date of signature, unless otherwise expressly revoked by us in writing prior to that time.

I HAVE READ AND UNDERSTAND THIS AUTHORIZATION. I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER THE ABOVE STATED TERMS.

Our Kids Authorized Representative Name: ____________________ Phone#: ____________________

Our Kids Authorized Representative Signature: ____

I understand that the specific information to be used or disclosed may include, but is not limited to: history, diagnosis, treatment of drug or alcohol abuse protected under 42 U.S.C § 290dd-2 and §397.501 Fla. Stat., treatment of mental illness protected under §394.4615, Fla. Stat., or communicable disease, including human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) protected under §381.004, Fla. Stat, as well as, education/school records, if such information exists. I understand that Our Kids reserves the right to disclose the minimum necessary information as per HIPAA rule. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected under this Agreement.

Form to be indexed in ASK under Medical Records: Authorization to Release Medical Records.