I _____ authorize Pediatric Partners to discuss/share protected health information about me with the following individual(s) who are involved in my care:

NAME:	RELATIONSHIP:	PHONE NO.:
NAME:	RELATIONSHIP:	PHONE NO.:
NAME:	RELATIONSHIP:	PHONE NO.:

Type of information to be shared or disclosed:

_____ Appointment information
_____ Mental Health information
_____ Prescription information
_____ ALL information

I authorize Pediatric Partners to leave detailed phone messages about my medical and health plan information with the following:

_____ Voicemail
_____ Person answering

This authorization shall remain in effect until revoked in writing by the patient.
Submitting a new form will revoke existing form.

X _____ X _____
SIGNATURE OF PATIENT/AUTHORIZED INDIVIDUAL DATE

Pediatric Partners
3401 PGA Blvd # 300
Palm Beach Gardens, FL 33410
Phone Number: (561) 741-0000
Fax Number: (561) 741-0002

Pediatric Partners
1025 Military Trail, # 109
Jupiter, FL 33458
Phone Number: (561) 741-0000
Fax Number: (561) 741-0002

Pediatric Partners
5458 Town Center Road #101
Boca Raton, FL 33486
Phone Number: (561) 393-8555
Fax Number: (561) 393-1904