

Authorization to Release Records & Verify Legal Authority

Practice Information

Practice Name: Pediatric Neuropsychology Associates, PLLC

Provider Name:

NPI / License No. (if applicable):

Practice Address:

Phone:

Email:

Introduction

At Pediatric Neuropsychology Associates, PLLC, we are committed to protecting the privacy and confidentiality of our patients' health information. This form authorizes the release of medical and psychological records for minor patients and includes a verification process to confirm the legal authority of the requesting individual.

In compliance with HIPAA and Florida law, valid legal documentation verifying parental rights, custody, or guardianship must be provided before any records for a minor patient are released. This ensures that only those with legal authority can access protected health information (PHI).

Please complete this form in full and attach the necessary documentation so we can process your request promptly and securely.

SECTION 1: Minor Patient Information

Patient Full Name:

Date of Birth:

Parent(s)/Legal Representative(s) Full Name(s):

Date of Birth:

Relationship to Patient:

SECTION 2: Request for Records

☐ Send records TO:

☐ Receive records FROM:

Name of recipient/organization:

Address / Fax / Email:

Purpose of Request (e.g., continuity of care, legal, school):

The recipient named above is responsible for maintaining the confidentiality of records received and complying with applicable privacy laws.

SECTION 3: Legal Guardianship Verification (Required)

Please select the option that best describes your legal authority to request records and attach the required documentation.

- ☐ I am the biological parent with full legal custody (no restrictions apply).
- ☐ I share joint legal custody with another parent (attach custody agreement).
- ☐ I am the court-appointed legal guardian.
- ☐ I am the adoptive parent.
- ☐ I am the foster parent (attach placement or DCF documentation).
- ☐ I have power of attorney for medical/legal decisions (attach notarized POA).
- ☐ I have temporary or court-ordered custody (attach court order specifying scope and duration).
- ☐ Other (please specify):

Attach one of the following legal documents verifying authority (required):

- ☐ Court custody agreement
- ☐ Letter of guardianship
- ☐ Adoption documentation
- ☐ Foster placement letter or DCF documentation
- ☐ Power of Attorney
- ☐ Other legal document:

Note: Records will not be released without valid legal documentation verifying authority to authorize this request. If there are joint custody arrangements or court-imposed limitations, please provide the most current legal documentation. In Florida, both parents generally have access unless rights are explicitly limited by court order.

In limited circumstances under Florida law, a minor may consent to certain mental health services independently. In such cases, access to records may be restricted as permitted or required by law.

Pediatric Neuropsychology Associates, PLLC reserves the right to request valid photo identification and additional documentation to verify identity and legal authority before releasing records.

SECTION 4: Records to Be Released

I authorize the release of the following records (check all that apply):

- ☐ Full Psychological Record
Includes evaluation reports, diagnoses, treatment history, and clinical documentation maintained as part of the designated record set, excluding psychotherapy notes unless otherwise authorized or required by law.
- ☐ Diagnosis & Treatment Summary
Includes active and past diagnoses, dates of service, and a general summary of treatment goals and progress.
- ☐ Psychological Testing Reports Only
Includes formal assessment results, interpretations, test scores, and diagnostic impressions.
- ☐ Session/Progress Notes
Includes administrative and clinical progress notes from individual or follow-up sessions, attendance logs, and clinician observations, excluding psychotherapy notes as defined by HIPAA.
- ☐ Educational or School-Related Reports
Includes records specifically created for school purposes such as IEP/504 consultation notes, school communications, and academic recommendations.
- ☐ Other:
- ☐ Records from the following date range: to

Preferred Delivery Method:

Secure Methods (Preferred):

- ☐ Secure Portal
- ☐ Mail
- ☐ Fax
- ☐ Other (must be authorized by parent/legal representative):

☐ Unencrypted/regular email (Only if explicitly authorized below)

☐ I understand and accept the risks of receiving protected health information (PHI) via unencrypted email. I authorize Pediatric Neuropsychology Associates, PLLC to send records using this method.

SECTION 5: Consent & Signature

I certify that I have the legal authority to request these records on behalf of the minor named above. I understand that once records are disclosed to the recipient named in this form, they may no longer be protected under HIPAA and may be subject to re-disclosure by the recipient.

I understand that I may revoke this authorization at any time by submitting a written request to Pediatric Neuropsychology Associates, PLLC, except to the extent that records have already been released based on prior authorization.

I also understand that I am not required to sign this authorization and that refusal to sign will not affect the patient's ability to receive treatment, payment, enrollment, or eligibility for benefits.

This authorization will expire one (1) year from the date of signature, unless an earlier expiration date is specified here:

, or the authorization is revoked in writing prior to that date.

I acknowledge that reasonable fees for copying, mailing, or secure electronic transfer may apply as allowed by Florida law.

I certify that my authority to request these records has not been limited, suspended, or modified by any court order not disclosed to the practice.

I understand that this authorization is limited to the release of records and does not constitute consent for treatment, evaluation, or services.

Electronic Signatures and Records

By signing this form electronically, I agree that my electronic signature and any related electronic records shall have the same legal validity and enforceability as a handwritten signature and paper documents. I acknowledge the use of electronic records for this agreement.

Parent or Legal Representative Consent and Acknowledgment (for Minors or Individuals Lacking Legal Capacity)

I acknowledge that I have received, read, and understood the Pediatric Record Release & Guardianship Verification of Pediatric Neuropsychology Associates PLLC. By signing below, I confirm that I am the parent or legal representative of the patient named below, and that I have the authority to consent on their behalf.

Printed Name of Patient:

Printed Name of Parent/Legal Representative:

Signature of Parent/Legal Representative:

Relationship to Patient:

Date:

A copy of this signed form will be retained in the patient's health record.

Staff Use Only

☐ Legal authority verified (type of document):

☐ Copy of valid photo ID received

☐ Consent reviewed for unsecured communication (if applicable)

☐ Staff initials:

☐ Date: