

FLORIDA HEALTH IN MIAMI-DADE COUNTY PEDIATRIC DEMOGRAPHIC FORM WEB APPLICATION

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INITIATION OF SERVICES

PART I	CLIENT-PROVIDER RELATION	NSHIP CONSENT	
Client Name:			
Name of Agency:			
Agency Address:			
understand routine examination, admiBy initials the provision of so	e health care is confidential and volunta inistration of medication, laboratory tests ar- ing this line, I acknowledge that I have been	norize Department of Health staff and their representatives to rearry and may involve medical visits including obtaining med and/or minor procedures. I may discontinue this relationship at an provided with a Telehealth Informed Consent Informational Selehealth. I may withdraw my consent at any time by discontinut.	ical history, assessment, any time. Theet and that I consent to
psychiatric/psycho being shared in the centers, and other	use and disclosure of my health information ological, and case management; for treatme e Health Information Exchange (HIE), allow	ON CONSENT (treatment, payment or healthcare operations nation; including medical, dental, HIV/AIDS, STD, TB, subsent, payment and health care operations. Additionally, I consent wing access by participating doctors' offices, hospitals, care coordinates. If you choose not to share your information in the	stance abuse prevention, to my health information ordinators, labs, radiology
PART III REQUEST (Onl	MEDICARE PATIENT CERTING Applies to Medicare Clients)	IFICATION, AUTHORIZATION TO RELEASE	, AND PAYMENT
is correct. I authora related Medicare	rize the above agency to release my health	rmation given by me in applying for payment under Title XVIII information to the Social Security Administration or its intermed benefits be made on my behalf. I assign the benefits payable of Medicare for payment.	diaries/carriers for this or
The amount of suc		named agency all benefits provided under any health care plan carges set forth by the approved fee schedule. All payments under	
DADEN	COLLECTION LICE OF DELETA	CE OF COCIAL CECUDITY NUMBER	
PART V		SE OF SOCIAL SECURITY NUMBER	
For health care proby subsections 119 security number for	9.071(5)(a)2.a. and 119.071(5)(a)6., Floridary identification and billing purposes only.	ay collect your social security number for identification and billing a Statutes. By signing below, I consent to the collection, use of It will not be used for any other purpose. I understand that the color the performance of duties and responsibilities as prescribed by	or disclosure of my social ellection of social security
PART VI OF PRIVACY		IFIES THE ABOVE INFORMATION AND RECEIP	T OF THE NOTICE
Client/Representat	tive Signature S	Self or Representative's Relationship to Client	Date
Witness (optional)		Date	
PART VII	WITHDRAWAL OF CONSENT		
I.	WITHDR	AW THIS CONSENT, effective	
Client/R	depresentative Signature	Date	