Family Medical Center
2863 S. Delaney Ave.
Orlando, FL 32806
407-843-1620
407-843-5243

# AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Full Name: _____ Date of Birth: _____

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 [45 CFR§164.508]. I authorize the above named practice, my physician and/or administrative and clinical staff to (check all that apply):

_____ Use the following protected health information, and/or

_____ Disclose the following protected health information to [*Name of entity or class of persons to receive information*]:

_____

_____

Description of information to be used or disclosed:

_____

_____

This protected health information is being used or disclosed for the following purposes: [*List specific purposes here. "At the request of the individual" is acceptable if the request is made by the patient, and the patient does not want to state a specific purpose.*]

_____

_____

This authorization shall be in force and effect until: (1) _____ [*expiration date*] date or (2)

_____ [*event that relates to the patient or the purpose of the use or disclosure]* at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Practice's Privacy Officer at the above practice address. I understand that a revocation is not effective to the extent that the above named has relied on the use of disclosure of the protected health information

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or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment, in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except: (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. I understand that I may refuse to sign this authorization.

If the use/disclosure is for marketing, I understand that the use or disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party. _____ [*Patient Initials if applicable].*

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Description of Personal Representative's Authority