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

Authorization to Disclose Protected Health Information

This form is for all record requests.

RELEASE INFORMATION FROM:

SPECIFY PROVIDER/ORGANIZATION NAME AND FACILITY ADDRESS

Organization Name: _____

Address: _____

_____

Ph#: _____ FAX#: _____

RELEASE INFORMATION FROM:

SPECIFY PROVIDER/ORGANIZATION NAME AND FACILITY ADDRESS

Organization Name: _____

Address: _____

_____

Ph#: _____ FAX#: _____

By signing this Authorization, I authorize my Health Care Provider to disclose my protected health information.

INDENTIFYING INFORMATION AT THE TIME OF SERVICE

PATIENT'S FULL NAME _____

MAIDEN OR OTHER NAME _____

DATE OF BIRTH _____/ _____/ _____ SSN/MEDICAL RECORD #_____

ADDRESS _____

Covering the period(s) of health care:

FROM (Date) _____ TO (Date)_____

1. INFORMATION AUTHORIZED FOR DISCLOSURE, *IF INCLUDED IN MYRECORDS*:

- ☐ COMPLETE HEALTH RECORD
- ☐ VISIT/DISCHARGE SUMMARY
- ☐ CLINICAL DOCUMENTATION OF CONSULTATION
- ☐ IMMUNIZATION RECORDS
- ☐ PROGRESS REPORTS
- ☐ RADIOLOGY AND DIAGNOSTIC IMAGING REPORTS
- ☐ PHOTOGRAPHS, VIDEOS, DIGITAL, OR OTHER IMAGES
- ☐ PATHOLOGY REPORTS
- ☐ LABORATORY TESTS (*PLEASE SPECIFY)*
- ☐ OTHER (*PLEASE SPECIFY)*

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2. IF APPLICABLE, I ALSO GIVE PERMISSION for the following "Sensitive Protected Health Information" to be disclosed (*please initial below):*

- ☐ ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV)
- ☐ BEHAVIORAL HEALTH SERVICES/ PSYCHIATRIC CARE
- ☐ TREATMENT FOR ALCOLHOL AND/OR DRUG ABUSE
- ☐ SEXUALLY TRANSMITTED DISEASES (STD)
- ☐ GENETIC COUNSELING/TESTING

_____I UNDERSTAND THAT THE INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION, **EXCEPT** INFORMATION PROTECTED BY FEDERAL AND/OR STATE REGULATIONS ABOUT CONFIDENTIALITY OF DRUG AND ALCOHOL ABUSE RECORDS, HIV AND MENTAL HEALTH, MAY BE SUBJECT TO RE- DISCLOSURE BY THE RECIPIENT AND NO LONGER PROTECTED BY FEDERAL PRIVACY REGULATIONS OR OTHER APPLICABLE STATE AND FEDERAL LAWS.

3. THE PURPOSE FOR WHICH DISCLOSURE IS AUTHORIZED (*CHECK WHEN APPLICABLE):*

☐ MEDICAL CARE ☐ INSURANCE ☐ BENEFIT ELIGIBILITY ☐ IMMUNIZATION

☐ OTHER: _____

4. I UNDERSTAND THAT I HAVE A RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME. I UNDERSTAND THAT IF I REVOKE THIS AUTHORIZATION I MUST DO SO IN WRITING AND PRESENT MY WRITTEN REVOCATION TO THE PROVIDER(S) OF CARE.
I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION.
I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO MY INSURANCE COMPANY WHEN THE LAW PROVIDES MY INSURER WITH THE RIGHT TO REVIEW OR CONTECT A CLAIM. UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL EXPIRE ON THE FOLLOWING DATE, EVENT, OR CONDITION:

(DATE) / / If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days. If this authorization pertains to oneself as the patient, the expiration date can be documented as unlimited. If documented as such, (Initial here) it is the responsibility of the individual to notify the practice of any life changes, i.e. guardianship, so that appropriate documentation is given for the change.

5. **I UNDERSTAND** THAT ANY DISCLOSURE OF HEALTHCARE INFORMATION CARRIES WITH IT THE POTENTIAL FOR UNAUTHORIZED AND FUTURE RE-DISCLOSURES, AS ALLOWED BY HIPAA AND OTHER FEDERAL PRIVACY RULES. IF I HAVE QUESTIONS ABOUT DISCLOSURES OF MY HEALTH INFORMATION, I CAN CONTACT MY PROVIDER OF CARE.

6. THIS FACILITY, ITS EMPLOYEES, OFFICERS, AND PHYSICIANS ARE HEREBY RELEASED FROM ANY LEGAL RESPONSIBILITY OR LIABILITY FOR DISCLOSURE OF THE ABOVE INFORMATION TO THE EXTENT INDICATED AND AUTHORIZED HEREIN.

_____

Signed: Patient – (or Legal Representative, Parent or Legal Guardian) (*Relationship if not Patient*)

ID Provided _____ Date _____

Witness or Notary (This Authorization must be notarized if information is being released to an attorney and/or court.

_____ _____

Official Use Only: Name/Title of person releasing information: Date