



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

Authorization For Use of Disclosure of Protected Health Information

Patients Full Name: _____ Date of Birth: _____

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996. I authorize the above-named practice, my physician, and/or administrative and clinical staff to disclose protected health information.

Please list the people in your life you would be comfortable with us speaking to if they were to come in or call:

Who [*Someone in your personal life*]: _____

Relationship to you? _____

Phone Number [*For identity verification*]: _____

Description of information to be used or disclosed [*Appointment info, Billing info, or Any Information*]:

—

Purpose of disclosure [*“To Keep Up With Medical Care” is an appropriate answer*]:

—

This authorization shall remain in effect until: [*1 year, 5 years, Forever, or another timeframe*]:

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I understand that I may revoke this authorization at any time by submitting a written request to the Practice's Privacy Officer. Revocation will not apply to information already used or disclosed in reliance on this authorization, or when authorization was required for insurance coverage, the insurer has a legal right to contest a claim. Information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected by federal or state law. My physician will not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization, except as permitted by law. I may refuse to sign this authorization.

Patient Signature: _____ Date: _____

Patient Representative Signature (if applicable): _____