AUTHORIZATION TO RELEASE OF MEDICAL RECORDS

☐ **Belle Glade** ☐ **Delray Beach** ☐ **Lantana** ☐ **WPB** ☐ **Golden** ☐ **RAMS** ☐ **Lewis**

Authorization for Use and Disclosure of Individually Identifiable Health information and Confidential Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

Patient: ____________________________________ ____
(Print Name) **DOB**

____ ____
Street Address **City, State, Zip**

AUTHORIZE MY CURRENT PHYSICIAN: **TO RELEASE PROTECTED HEALTH INFORMATION TO:**

____ ____
Provider's Name **Provider's Name**

____ ____
Street Address **Street Address**

____ ____
City, State, Zip **City, State, Zip**

______________________ __________________ __________________ _______________________
Phone # **Fax #** **Phone #** **Fax #**

INFORMATION THAT MAY BE USED/DISCLOSE:

☐ Complete Health Record	☐ Progress Notes	☐ Mental Health Records
☐ H&P	☐ Consultation Reports	☐ X-rays Reports
☐ Discharge Summary	☐ Photos, Tapes, Digital Pictures	☐ HIV Testing/Treatment
☐ Laboratory Tests	☐ Medical Claims/Invoices	☐ Drug/Alcohol Treatment
☐ Other	☐ Prescriptions	☐ Sexual Assault/Victimization Records
☐ Psychiatric evaluation	☐ Psychiatric Record	

The information described above is to be disclosed for the following purposes:

I acknowledge and agree that the practice may disclose my protected health information and information contained in my medical record to the following (check allowances)
☐Spouse______________________________ ☐Adult Children______________________________ ☐Legal Representatives_________________________ _____
☐Guardians_____________________________ ☐Health care Surrogates____
☐ Other ________________________________ ☐**ALL LISTED.**

I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign or my revocation of this authorization will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law.

I understand that I may inspect or request copies of the information used or disclosed by this authorization. This authorization will expire one year from execution if no Authorization Date is given.

Authorization Expiration Date: __________________________

I understand that I may revoke this authorization at any time by notifying the CL Brumback Primary Care Clinic HCD providing the information in writing, except to the extent that (a) action has been taken in reliance on this authorization; or (b) if this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy.

I have read and agree to the information regarding "How We May Use and Disclose Medical Information About You." Our notice of "Privacy Practices" (posted in reception) provides information about how we may use and disclose health information about you. You have the right to review our notice before signing this form. The practice reserves the right to change the terms of its Notice of Privacy Practices at any time. If so, the patient may obtain a copy of this revised Notice. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations.

I have read and understand the information in this authorization.

____ ____
Signature of patient or patient's representative **Date**

____ ____
Basis of representative authority to act for patient is **Witness**