CENTRAL FLORIDA
Family Practice

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Date: _____

Patient's Name: _____

Date of Birth: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Telephone: _____ **Email:** _____

I, _____, *authorize the use and disclosure of health information as described below:*

Facility Authorized to Release my Health Information: _____

Agency/Individual(s) Authorized to Receive my Health Information: Central Florida Family Practice

Address: 4513 Old Canoe Creek Road _____

City: St.Cloud **State:** FL **Zip Code:** 34769

Telephone: 407-498-0461 **Fax:** 407-891-1353

Health Information may be used/disclosed is limited to the following:

• History & Physical	• Progress Notes & Consultations	• Lab Results
• Diagnostic Results	• Entire Medical Record	
• Other *(Specify)*:		

Health Information that may be used/disclosed is limited to the following periods of healthcare:
From (date): ALL To (date): ALL
From (date): _____ To (date): _____

Health information to be released to the above name agency/individual(s) is to be used/disclosed for the following purposes:

• Treatment/Consultation	• Billing or Claims Payment	• Research

• At the Request of the Patient	• At the Request of the Employer
• Other *(Specify)*:	

"Health Information" identifies you (the patient) by name, and includes other demographic information about you. "Health Information" may include, but is not limited to: medical records, X-Ray Films, slides, tracings, strips, etc.

I hereby discharge the releasing facility, its agents and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of information authorized herein, ***to include alcohol, drug abuse, communicable disease including HIV status, and or psychiatric diagnoses*** compiled during my visit encounter or hospitalization, or make copies thereof in accordance with the policies of this facility.

• **Yes**	• **No**	If applicable, I agree to the release of my medical or billing records containing the ***sensitive information*** listed above.

Protected Health Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected by this privacy rule. If research-related Health Information is used or disclosed for continued research purposes, and expiration date or event does not apply.

This authorization will automatically *expire 90 days* after the date of signature below (except as indicated below), unless an earlier date is specified, or at the conclusion of a specified event. I understand that I have a right to revoke this authorization at any time, in writing, except where the facility has already made disclosures in reliance upon my prior authorization.

Treatment, payment enrollment or eligibility for benefits may not be conditioned on obtaining an authorization if the HIPAA prohibits such conditioning. If conditioning is permitted, refusal to sign the authorization may result in denial of care of coverage.

NOTICE TO RECEIVING AGENCY OR INDIVIDUAL: This information is to be treated in accordance with (HIPAA) privacy regulations.

Patient's or Authorized Personal Representative's Signature*		Date	Time
Relationship to Patient/Authority to Act on Patient's Behalf		Interpreter, if Utilized	
Witness's Signature	Date	Time	Expiration Date or Event
• **Signature validated against driver's license or signature in Medical Record. There may be a charge for copying Medical Records* • Electronic Copy Requested			