BRANDON RIVERVIEW
MEDICAL ASSOCIATES

Authorization for Release of Protected Health Information

Patient Name		DOB			
SS #		Phone			
Address					
City		State		Zip	

I hereby authorize Brandon Riverview Medical Associates, to use and/or disclose the above-named individual's protected health information as described below.

Facility: ___________________________ **Address:** ___________________________ **Phone:**_____________**Fax:** ______________

- ☐ History and Physical Examination
- ☐ Termination
- ☐ Consultation Reports
- ☐ X-ray and Imaging Reports
- ☐ Medication Sheets
- ☐ Other (describe): ____
- ☐ Complete health records without limitation
- ☐ Staff/Physician Progress Notes
- ☐ Order Sheets
- ☐ Operative/Pathology Reports
- ☐ Laboratory and/or Test Results

This information may be disclosed to and used by the following:

Brandon Riverview Medical Associates

☐ 519A East Bloomingdale Avenue
Brandon, FL 33511
Phone: 813.655.4100
Fax: 813.655.1775

☐ 13111 HWY 301 South
Riverview, FL 33578
Phone: 813.671.0064
Fax: 813.672.2153

☐ Self
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This information is used for the purpose of continuity of care, unless otherwise noted: ________________________________

I specifically authorize the release of any and all information relating to:

- ☐ AIDS Related Records/HIV Test results (Test for Aids)
- ☐ Psychiatric/Behavioral/Mental Health Notes
- ☐ Treatment for alcohol and /or drug abuse

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 must present my written revocation to the Privacy Officer of Brandon Riverview Medical Associates. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____________________________. If I fail to specify an expiration event or condition, this authorization will expire in one (1) year, except to the extent that action has been taken thereon.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand Brandon Riverview Medical Associates may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand that I may inspect or copy information to be used or disclosed, as provided by federal and state law. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by applicable federal or state confidentiality rules. If I have questions about disclosure of my health information, I can contact the Center Manager or the Privacy Officer at 813-655-4100.

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Signature of Individual or Legal Representative

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Date

____
If Signed by Legal Representative, Relationship

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Signature of Witness