Orlando & St. Cloud Family Medicine

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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

All Portions of this form ***must*** be completed to constitute a valid authorization for release of health information under the Health Insurance Portability and Accountability Act (HIPAA) privacy regulations. If any field is left blank, the authorization will be considered defective.

I,_____hereby authorize the use of this disclosure.
PRINT (Parent/Legal Guardian Name) or (Patient/Legal Representative)

This authorization will expire on the following date, event or condition: 1 year from the date of this request. If I fail to specify an expiration event or condition, the authorization will expire after one year. I understand that this authorization is revocable at any time upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. Diagnosis or treatment of mental health, alcohol, drug and/or HIV and/or AIDS status is sensitive information that is confidentially protected by Federal and state law which prohibits disclosure without specific written authorization of my record be released without my written authorization, except as otherwise required by law. I understand that I may select the information of the list below to be released by placing my initials in the space provided. Furthermore, I understand that any disclosure of information from my records carries with it the potential for unauthorized re-disclosure of my health information by the recipient and is no longer protected by this privacy rule. I further understand that Orlando & St. Cloud Family Medicine may not condition treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision on this authorization.

1. I authorize Orlando & St. Cloud Family Medicine the use and/or disclosure of health Information about me as described below to be:
   ___ Release to OR ___Obtain from

Name of Healthcare Provider/Physician/Facility/SELF*	Telephone Number*: ( ) -
Address City/State/Zip	FAX Number*: ( ) -

2. For the following purpose(s) of:

   _____Treatment/Consultation _____Patient Request _____Legal Request
   _____Moving out of Area _____New Local Physician X Other (specify): continuity of care

Requested Date(s) of Service:	From:	To: *Present*

3. STANDARD REQUEST: Place your **INITIALS** by each item to be released or reviewed

   _____Complete Record (fees may apply) _____Progress/Consultation Note(s) _____Lab Only
   _____Pathology/Operative Report(s) _____All Diagnostic Test Results _____Radiology Record(s)

   X Other (specify): Continuity of care: MMG, Colonoscopy, Eye Exam, Pap Smear _____

4. ADDITIONAL INFORMATION: In addition, place your **INITIALS** by each specific item: (if applicable)

   ___Mental Health ___Drug and/or Alcohol ___HIV Testing ___AIDS Information ___STD/Communicable Disease

5. _____ _____
   Signature of Patient/Legal Representative or Parent/Legal Guardian Name Date of Authorization Interpreters, if Utilized

   _____ _____ _____
   Patient Date of Birth Social Security Number (optional) Telephone Number

   _____
   Address City/State/Zip

   Witness: _____ _____
   Printed Name of the Witness to Authorization Date