Authorization of Use and Disclosure of Protected Health Information

Patient Name: _____

Date of Birth: _____ SSN: _____

I. My Authorization

You, Flagler Family Medicine may use or disclose the following health care information:

☐ **ALL** my health information maintained by you.
☐ My health information relating to the following treatment or condition: _____
☐ My health information for the date(s):_____
☐ Other: _____

You may disclose this health information to:
Name (or title) and organization: _____
Relationship: (parent, child, sibling, legal guardian, etc,): _____

Name (or title) and organization: _____
Relationship: (parent, child, sibling, legal guardian, etc,): _____

Name (or title) and organization: _____
Relationship: (parent, child, sibling, legal guardian, etc,): _____

This Authorization ends: ☐ on (date) _____
☐ When the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization in order to receive treatment. However, I may be required to sign this authorization form:

- To take part in a research study; or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization at any time, in writing, sent to Flagler Family Medicine at the address provided below. If I do, it will not affect any actions already taken by Flagler Family Medicine based upon this authorization; uses and disclosures already made cannot be taken back. I may not be able to revoke this authorization if its purpose was to obtain insurance.

- 130 Health Park Blvd St Augustine, FL 32086
- 28 Old Kings Rd North Suite A, Palm Coast, FL 32137
- 315 W Town Place Unit 1, St. Augustine, FL 32092

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____
Patient or legally authorized signature Date

Patient is unable to sign because of (minor, disabled, etc.) _____