AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

Address: _____ Telephone # _____

City/ State/ Zip Code: _____

I authorize Flagler Family Medicine to RELEASE my health information to:

_____

Name of Provider or Facility

_____

Address

_____

City, State, Zip Code

(Phone): _____ (Fax): _____

I authorize Flagler Family Medicine to OBTAIN my health information from:

_____

Name of Provider or Facility

_____

Address

_____

City, State, Zip Code

(Phone): _____ (Fax): _____

Provider Requesting Records: _____

The purpose of this disclosure is for: Continuity of Care or Transferring Care **Information of release by**: Electronic or Paper

Type of Requested Records:

Last two years only of

- Treatment Summary (including History & Physical, laboratory test results, x-ray reports, pathology, progress notes, therapy notes, EKG reports, immunization records, Behavioral Health/Psychiatric Care
- Additional records ER records, Cardiac Testing (Holder, Echo, Stress, etc.)
- Billing Records
- Specific Dates From: _____ To: _____
- Other Records _____

I understand that the information disclosed pursuant to this authorization may include information relating to the following unless specifically restricted below:

- Psychological/ psychiatric conditions
- Drug and /or alcohol abuse
- HIV/AIDS diagnosis and /or testing
- Genetic testing
- Sexually transmitted disease(s) diagnosis and /or testing

Please note: per State regulations, additional authorizations may be required for certain conditions.

List any restrictions: _____

Redisclosure of Information: I understand that once information is disclosed pursuant to this authorization that the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 C.F.R. Parts 160 and 164, protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, prohibit redisclosure.

Right to receive a copy of authorization: I understand that if I agree to sign this authorization, I must be provided with a signed copy of this form if I so request.

Right to Revoke: I may cancel this authorization at any time by submitting a written request to Flagler Family Medicine except where a disclosure has already been made in reliance on my prior authorization.

Expiration Date of this request is: _____ (I understand that unless I provide a written revocation at an earlier date, this authorization will expire in one year).

Signature of Patient or Legal Representative(s): _____ **Date:** _____

(Note: If patient is a minor child, both parents may be required to sign)

Printed Name(s): _____ **Relationship to Patient:** _____