Authorization for the Release of Protected Health Information

PATIENT NAME: _____ **DATE OF BIRTH:** _____

I hereby authorize _____, the use or disclosure of the above
(name of patient's provider receiving request)

named individual's health information as described below:

Hospital Records		**Hospital Records**		**Office Records**	
Admission H and P		Lab Reports		Medical History	
Discharge Summary		Procedure Reports		Recent Physical Exam	
Medication Records		Progress Notes		Current medications	
Operative Reports		Mental Health		Current Diagnoses	
Consults		Sensitive Information		Procedure Report	
Other		Other		Other	

The information identified above may be used or disclosed to the following individuals and/or organization:

Clearwater Office
2147 NE Coachman Road
Clearwater, FL 33765
Phone: (727) 466-0078
Fax: (727) 461-7793

Tampa Office
605 N. Howard Ave.
Tampa, FL 33606
Phone: (813) 870-1292
Fax: (813) 253-5700

- I understand that I have the right to revoke this authorization at any time. I understand that revocation must be given in writing and will not apply to information that has already been released in response to this authorization.
- I understand this information will be used for continuity of patient care or in the case of my demise during a clinical trial, for post-mortem documentation as required by the FDA.
- This authorization will expire ten years from date of signature, continues until the end of treatment, and covers future services.
- I understand that once the above information has been disclosed, it may be re-disclosed by the recipient and the information may not protected by federal privacy laws or regulations.
- I understand authorizing the use of disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment.

PATIENT SIGNATURE: _____ **DATE:** _____