SARASOTA FAMILY MEDICAL

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

INFORMED CONSENT:

I _____ DOB _____ SS# _____

HEREBY AUTHORIZE THIS OFFICE TO:

REQUEST COPIES OF MY MEDICAL RECORDS FROM

_____

_____

RELEASE COPY OF RECORDS TO :

SARASOTA FAMILY MEDICAL
6813 S TAMIAMI TRAIL
SARASOTA, FL. 34231
P (941) 923-5861 F (941) 926-4547

FOR SPECIFIC PURPOSE I HAVE CHECKED BELOW:

_____CONTINUED MEDICAL CARE _____ CHANGING PRIMARY CARE _____ MOVING OUT OF AREA
_____ OTHER (specify) _____

INFORMATION TO BE DISCLOSED: (Initial Selection)

_____ PROGRESS NOTES
_____ HISTORY AND PHYSICAL
_____ LAB RESULTS
_____ ALL MEDICAL RECORDS
_____X-RAY AND OTHER IMAGING STUDIES
_____CONSULTATION
_____OTHER

IN ADDITION TO THE FORGOING, I AUTHORIZE THE RELEASE OF THE FOLLOWING RECORDS (initial if appropriate)

_____ DRUG AND ALCOHOL ABUSE RECORDS
_____ PSYCHIATRIC OR PSYCHOLOGICAL RECORDS
_____ SEXUALLY TRANSMITTED DISEASE AND HIV RESULTS

EXPIRATION DATE: This authorization will expire on (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire six (6) months from the date on which it was signed.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

REVOCATION: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicare or Medicaid.

_____ _____
PATIENT OR LEGAL CUARDIAN'S SIGNATURE DATE SIGNED

_____ _____
WITNESS SIGNATURE DATE SIGNED

For office use only:
Date received _____ Date request completed _____ Initials _____

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_____SARASOTA, FLORIDA 34231_____

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