North Florida Women's Care
1401 Centerville Rd., P.O.B., Suite 202
Tallahassee, FL 32308-4638
Phone (850) 877-7241 – Fax (850) 877-1338

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient's Name_____
Last First Middle Maiden

Patient's Address _____ City _____ State ____ Zip _____

Date of Birth _____ Phone Numbers _____

PERSON OR ENTITY TO <u>RELEASE</u> INFORMATION:

Name _____
Address _____
City _____ State ____ Zip _____
Phone _____ Fax_____

PERSON OR ENTITY TO <u>RECEIVE</u> INFORMATION:

Name _____
Address _____
City _____ State____ Zip _____
Phone_____ Fax _____

SPECIFIC INFORMATION TO BE DISCLOSED (check as needed):

- ☐ Complete Medical Record
- ☐ Office Notes
- ☐ Lab Reports
- ☐ Mammogram Reports
- ☐ Pap Smear/ Biopsy Reports
- ☐ Billing Records
- ☐ Ultrasound Reports
- ☐ Surgery Records
- ☐ Obstetrical (OB) Records
- ☐ Other (specify)

FEE FOR COPIES
<u>For Personal Use:</u>
$1.00 per page up to 25 pages. Over 25 pages, $.25 cents per page. (according to Florida Law)

<u>For Continuing Care:</u>
No Charge (when we mail or fax)

DATES OF SERVICE: _____

PURPOSE: ☐ Changing Physicians, ☐ Personal Copy To Patient, ☐ Attorney, ☐ Insurance, ☐ Workman's Comp.
Other _____

This authorization will expire on: _____ (If no date specified, it will expire 60 days after date signed).

CHECK AND INITIAL BELOW:

☐ I DO ☐ I DO NOT authorize the release of information pertaining to specific laboratory test of HIV infection (Human Immunodeficiency Virus, the causative agent of AIDS), the results of such test, the diagnosis of **Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions**, and all medical records and clinical information relating thereto.
Initials of individual authorization: _____

☐ I DO ☐ I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and information pertaining to any evaluation, treatment and/or hospitalization for **mental health or psychiatric conditions**.
Initials of individual authorization: _____

☐ I DO ☐ I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and information pertaining to any evaluation, treatment and/or hospitalization for **drug or alcohol abuse, drug related and/or alcohol related treatment.** *Initials of individual authorization*: _____

When my health information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. The use of disclosure of the information identified above is voluntary and I need not sign this form to ensure health care treatment. I have read and understand the nature of this authorization and understand that it may be revoked upon my written request to the Privacy Officer, except to the extent that action has already been taken on this authorization. Releaser and its agents and employees are hereby authorized to obtain, inspect and reproduce such records and/or information and are hereby relieved of any responsibility of liability that may arise from the release or reproduction of such records and or information.

_____ _____
Signature of Patient or Patient's Representative WITNESS

_____ _____
Relationship to Patient (If applicable, attach document of guardianship or Power of Attorney) Date