

GAINESVILLE FAMILY PHYSICIANS

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ Date of Birth: _____

Address: _____

Phone #'s: _____

RECORDS BEING REQUESTED FROM

Name: _____

Address: _____

Phone #: _____ Fax # & Attn to Whom: _____

Note: _____

WHO IS REQUESTING RECORDS

Name: GAINESVILLE FAMILY PHYSICIANS

Address: 6900 NW 9TH BLVD, GAINESVILLE, FL 32605

Phone #: 352-333-6680 Fax # & Attn to Whom: 352-331-4006, ATTN: Med Records

Note: _____

Purpose of Disclosure: (Why are you requesting records) _____

DESCRIPTION	DATE(S)	DESCRIPTION	DATE(S)
<input type="checkbox"/> ALL PHI IN RECORD <input type="checkbox"/> History and Physical <input type="checkbox"/> Consult Report <input type="checkbox"/> Operative Report <input type="checkbox"/> Progress Notes <input type="checkbox"/> Demographics <input type="checkbox"/> Special Tests/Therapy	<i>If not ALL mark applicable boxes</i>	<input type="checkbox"/> Physicians Orders <input type="checkbox"/> Laboratory <input type="checkbox"/> Imaging/Radiology <input type="checkbox"/> Nursing Notes <input type="checkbox"/> Medication Records <input type="checkbox"/> Rehabilitation Services <input type="checkbox"/> Other:	

1. I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)
2. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable fee.
6. I will receive a copy of this form after I sign it, if I so choose.

I have read the above and authorized the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative

Date

Print Name of Person Signing

Relationship