BIGGERS
FAMILY MEDICINE

1307 Providence Rd.
Brandon Fl 33511
Office: 813-655-4646 Fax: 813-655-4113

Authorization to Disclose Protected Health Information

This form is for all record requests

Release Information From: Specify Provider/Organization Name and Facility Address	**Release Information To:** Specify Provider/Organization Name and Facility Address
Organization Name:_____	Organization Name:_____
Address:_____	Address:_____
_____	_____
_____	_____

By signing this Authorization, I authorize my health care provider to disclose my protected health information.

IDENTIFYING INFORMATION AT THE TIME OF SERVICE

PATIENTS FULL NAME_____

MAIDEN OR OTHER NAME_____

DATE OF BIRTH____/____/____ **SSN/MEDICAL RECORD #**_____

ADDRESS_____
Mailing Address, City, State, Zip

Covering the period(s) of health care:

FROM (Date)____/____/____ **TO** (Date) ____/____/____

1. Information authorized for disclosure, if included in my records:

- ☐ Complete health record
- ☐ Visit/Discharge Summary
- ☐ Clinical Documentation of Physical
- ☐ Documentation of consultation
- ☐ Immunization Records
- ☐ Progress Reports
- ☐ Radiology and Diagnostic Imaging Reports
- ☐ Photographs, Videos, Digital or Other Images
- ☐ Pathology Reports
- ☐ Laboratory tests (please specify)
  _____
  _____
- ☐ Other (please specify)
  _____
  _____

2. If applicable, I also give permission for the following "Sensitive PHI" to be disclosed **(please initial below):**

- ☐ Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)
- ☐ Behavioral Health Services / Psychiatric Care
- ☐ Treatment for Alcohol and/or Drug Abuse
- ☐ Sexually Transmitted Diseases (STD)
- ☐ Genetic Counseling / Testing

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_____ **I understand** that the information disclosed pursuant to this authorization, **except** information protected
Initial by Federal and/or State regulations about confidentiality of drug and alcohol abuse records, HIV and Mental Health, may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations or other applicable state and federal laws.

3. The purpose for which disclosure is authorized (check where applicable):

☐ Medical Care ☐ Insurance ☐ Benefit eligibility ☐ Immunization

Other:_____

4. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the provider(s) of care. **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 when the law provides my insurer the right to review or contest a claim. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days. If this authorization pertains to oneself as the patient, the expiration date can be documented as unlimited. If documented as such, (Initial here_____) **it is the responsibility of the individual to notify the practice of any life changes, i.e. guardianship, so that appropriate documentation is given for the change.**

EXPIRATION DATE _____/_____/_____

5. I understand that any disclosure of healthcare information carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPPA and other federal privacy rules. If I have questions about disclosures of my health information, I can contact my provider of care.

6. This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Signed: Patient—(or Legal Representative, Parent or Legal Guardian)	(Relationship if not Patient) Date_____/_____/_____

Official Use Only

Name/Title of Person Releasing Information:_____

Date_____/_____/_____