BIGGERS FAMILY MEDICINE
1307 PROVIDENCE ROAD
BRANDON, FL 33511
Phone (813) 655-4646 Fax (813) 655-4113

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO FAMILY MEMBERS

Name of Patient ______________________________ Date of Birth ____________

I hereby authorize medical providers and personnel of Biggers Family Medicine to discuss my protected health information with:

______________________________ Name	________________ Relationship
______________________________ Name	________________ Relationship
______________________________ Name	________________ Relationship

I understand that certain information cannot be released without specific authorization as required by state or federal law. By initialing the lines below, I authorize the release of the following protected or sensitive information.

_____ Information regarding the patient's diagnosis and treatment of HIV/Aids
_____ Psychotherapy notes from a Psychiatrist or Psychotherapist
_____ Treatment for alcohol or drug abuse reports

This authorization shall be in force and in effect from ______________ until ____________ at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

______________________________________ Signature of Patient	________________ Date