AUTHORIZATION FOR RELEASE, USE & DISCLOSURE OF HEALTH INFORMATION

Patient Name:_____ Date of Birth_____

Address: _____ Phone #_____

_____

_____ __Access Request to Copy/Inspect

I authorize the use/disclosure of health information about me as described below:

1. The following organization is authorized to make the disclosure: **(from whom are we requesting the records?)**

   Name of Facility: _____

   Address: _____

   _____

   Telephone #: _____ Fax #:_____

2. **The type of information to be used or disclosed:** **Dates of service:** _____

   __ **Complete Medical Record** __ History & Physical __ X-ray & imaging reports

   __ Consultation Reports __ Discharge Summary __ Progress Notes

   __ Laboratory Test Results ✓ Immunization Record __ E.R. notes

   __ **Other** (Liist specific items) _____

   Behavioral Health Reports:

   __ Psychological Evaluation __ Social History __ Treatment Plan __Academic History

   __ **Other** (List specific items): _____

3. I understand that the information in my health record may include information relating to sexually transmitted diseases, **AIDS**, or **HIV.** It may also include information about behavioral or mental health services, and treatment of alcohol abuse.

This information is being provided to you from records whose confidentiality may be protected by States and /or Federal law.

4. I understand that your facility may receive compensation for medical record copying in accordance with the State law.
5. This information may be disclosed to and used by the following individual/organization: **(to whom the records are being sent**

B.J. ANARUMO, PA, DO
18308 Murdock Circle, Unit 103
Port Charlotte, FL 33948
941-629-3618 629-9809 Fax

For the purpose of:

__Further Medical Care __Changing Physicians __ Insurance Change __ Personal Copy

__Moving __ Other (please explain)_____

6. I understand I have the right to inspect and obtain a copy of my protected health information in the designated record sets you maintain. I understand, however, I am not entitled to inspect or obtain a copy of any psychotherapy notes or any information compiled in anticipation of use of or for any civil, criminal or administrative action or proceeding, any information not subject to disclosure under the Clinical Laboratory Improvements Amendments of 1988, (42 U.S.C. section 263 (a). and certain other records.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used or disclosed und ether authorization as described in #7 above.

8. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under the terms of the authorization.

9. I understand that I may revoke this authorization in writing at any time. To understand that if I revoke this authorization, I must do so in writing and present my written revocation the Health Information Management Department. I understand that the revocation will not apply to information that has already been release in response to this authorization. This authorization expires within 90 days, unless otherwise specified.

_____ _____

Signature of Patient Date

(If signed by person other than the patient, state relationship and authority to do so.)

_____ _____

Name of patient (please print) Date of Birth

Patient is: __ Minor __Incompetent __Disabled __Deceased

Legal Authority: __Custodial Parent __Legal Guardian __Power of Attorney for Health Care __Authorized Legal Personal Representative

_____ _____

Signature of Witness Date