

**AUTHORIZATION FOR USE AND/OR DISCLOSURE OF
PROTECTED HEALTH INFORMATION
(MEDICAL RECORD)**

SECTION A: Must be completed for ALL Authorizations

By signing this Authorization, I hereby authorize and permit the use and/or disclosure of my protected health information (medical record) for the limited purpose(s), and in the limited manner, described in this form. In addition, I understand that this Authorization is completely voluntary and I am signing it under my own free will.

Patient Name: _____ Patient # _____

Home Address: _____ Date of Birth: _____

Persons/organizations providing the information: (Complete w/Address)

Persons/organizations receiving this information: (Complete w/Address)
MT. DORA PEDIATRICS
(352) 383 0758 fmp

Specific description of information (including date(s)) to be used and/or disclosed about me:
All

- The following items must be initialed to be included in the use or disclosure of other health information:
- * HIV/AIDS related health information and/or records.
 - * Mental health information and/or records.
 - * Genetic testing information and/or records.
 - * Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed. Federal law prohibits the disclosure of such information.)
- _____

SECTION B: Must be completed only if FPMG has requested the Authorization

1. FPMG must complete the following:
 - a. What is the purpose of the use or disclosure? (Check one.)
 - At the patient's (or the patient's representative's) request or direction.
 - For marketing.
 - For fundraising.
 - Other (describe): _____
 - b. Will the FPMG practice requesting the Authorization, receive financial or in-kind compensation, directly or indirectly, in exchange for using or disclosing the health information described above?
 - Yes
 - No

2. The patient or the patient's representative must read and Initial the following statements:

a. I understand that my health care and the payment for my health care will NOT be affected if I DO NOT sign this form.

Initial: _____

b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it.

Initial: _____

SECTION C: Must be completed for ALL Authorizations

The patient or the patient's representative must read and initial the following statements:

1. I understand that this Authorization will expire. (Please choose one.)

No expiration (permitted only for Authorizations used to create or maintain research databases or repositories).

Initial: _____

On _____ (DD/MM/YYYY)
Date

Initial: _____

When the following event occurs

Initial: _____

Signature of Patient or Patient's Representative
(Form MUST be completed before signing)

Date

Print Name of Patient's Representative: _____

Relationship to the Patient: _____

Reason Authorization is signed by the Patient's Representative: (Check one.)

Minor

Incompetent

Other (Explain) _____

*** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**

**If this Authorization form authorizes use and/or disclosure of psychotherapy notes, it may not be used to authorize the use and/or disclosure of any other protected health information. A separate Authorization form is needed for any other use and/or disclosure.*