AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

_____ hereby authorizes the use or disclosure of the individually
Print Patient/Legal Representative or Parent/Legal Guardian Name

identifiable health information of _____ as described herein.
Print Patient Name Date of Birth

Person/organization authorized to use/disclose the information:	Person/organization authorized to receive the information:
Name/organization _____	Name/organization Barimo Family Medicine
Address _____	Address 483 N. Semoran Blvd. #206
City, State, Zip _____	City, State, Zip Winter Park, FL 32792
Phone _____ Fax _____	Phone 407-678-2400 Fax 407-678-4926

***IMPORTANT: If there are more than 10 pages, please mail.**

For the purpose of: ☐ Legal Request ☐ Moving out of Area ☐ New Local Physician ☐ Other (please specify)

_____

This authorization will expire on the following date, event or condition: _____
if I faill to specify an expiration event or conditioin, this authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorizatioin is retained, except to the extent that service has already been taken on the authorization. Mental health, alcohol, drug, HIV and/or AIDS information is confidentially protected by Federal and state law which prohibits disclosure without specific written authorization of the undersigned, or as otherwise permitted by such regulations. I futher requeset that no genetic counseling/testing information in my record be released without my written authorization, except as otherwise required by law. I understand that I may select the infomation from the list below to be released by placing my initials in the space provided. Furthermore, I understant that any disclosure of information from my records carries with it the potential for an unauthorized re-disclosure of my health information. I further understand that Physician Associates, LCC may not condition the provision of treatment, payment, enrollment in the health plan, or ellgibility for benfits on the provision of this authorization.

Date(s) of Service: From: _____ To: _____

Place your INITIALS by each item to be released or reviewed:

_____ Abstract of Record _____ All diagnostic test results _____ Pathology
_____ Radiology only _____ Consultation/Progress Note(s) _____ Lab Only
_____ Complete Record (charges may apply) _____ Other (specify)

In addition, place your INITIALS by each specific item: (if applicable)

_____ Mental Health _____ HIV Testing _____ Genetic Counseling/Testing Information
_____ Drug and/or Alcohol _____ AIDS Information _____ STD/Communicable Diseases

_____ _____
Patient/Legal Representative or Parent/Legal Guardian Signature Required Date of Authorization

_____ _____ _____
Patient Date of Birth Social Security Number (optional) Identification Shown

_____ _____
Translator or Interpretor's Name Telephone Number

_____
Address City State Zip Code

Official Use Only: _____
Name of Person Releasing Information Date