Authorization for Release of Medical Records

To: MEDICAL RECORDS DEPARTMENT

Telephone: Fax:

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that is authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider; the released information may no longer be protected by federal privacy regulations.

This authorization includes release of information concerning AIDS/AIDS-related conditions, HIV/HIV-related conditions, AIDS/HIV testing, drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric and or psychological conditions.

Person/Organization Providing the Information

_____
_____
_____
_____

the Person/Organization Receiving Information

Internal Medicine & Pediatrics of Tampa Bay
10111 Wilsky Blvd.
Tampa, FL 33625
Phone Number: (813) 961-2222
Fax Number: (813) 961-2220

Specific description of information requested

_____
_____
_____

Purpose or need for release:
___ Info for Insurance Co. __ Info for Attorney ___ Transfer To New PCP
___ Copy to PCP for Plan of Care Info

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

1. I understand that this authorization will expire on 12/31/2025. **Initials: _____**

2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do, it won't have any affect on any actions they took before they received the revocation.
Initials: _____

Patient Name: _____ Date of Birth: _____

Social Security #: _____

Signature: _____ Date: _____

If above signature is not the patient's, please print name and relationship to patient:

Name of responsible party: _____ Relationship: _____