Affiliated Health Clinics, LLC

3600 Central Avenue

St. Petersburg , Florida 33711

727-322-4227 Phone

727-322-4656 Fax

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____ _____ _____ **Patient Record Number:** _____
Last First Middle

Date of Birth (mm/dd/yyyy)**:** _____/_____/_____**Phone Number:** _____

Address:_____**City/State/Zip**_____

I understand this information will be [ ] disclosed to or [ ] obtained from:

Name: _____ Phone: (_____)_____

Address: _____ City/State/Zip: _____

The purpose for such disclosure is:

☐ Further Medical Care ☐ Changing Physicians ☐ Insurance Eligibility/Benefits ☐ Personal

☐ Other (specify): _____

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, which must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed without obtaining my authorization.

Information to be released: ☐ Entire Record ☐ Only the parts of the medical record that I specify: _____

☐ Ultrasounds ☐ Pap Smear ☐ Hospital Records ☐ Labs ☐ Other: _____

_____

Privilege Box

In compliance with applicable laws, the information listed below **cannot be released without my specific consent and knowledge**. Therefore, I have **initialed** (no other mark is acceptable) before each type of record that I authorize you to release:

_____ Alcohol and/or drug abuse treatment records _____ AIDS, HIV, or HIV testing records _____ Genetics
_____ Mental Health treatment records _____ Sexually transmitted diseases records

Your Rights With Respect To This Authorization:

Right to Inspect or Copy the Health Information to Be Used or Disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information by contacting the Privacy Officer at (727)322-4227. **Right to Receive Copy of This Authorization** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization** – I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Privacy Officer at (727)322-4227. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization. I hereby release Affiliated Health Clinics, providers, employees, contracted agents, and its staff from all liability and all claims of any nature pertaining to the lawful disclosure of the information described above.

Expiration Date: This authorization is effective until the following date _____ or 90 days from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Name (please print): _____ Signature: _____ Date: _____

Relationship to patient: _____

Witness name (please print): _____ Signature: _____ Date: _____

FOR OFFICE USE ONLY

Picture identification shown (specify):_____

Date requested: _____ Date completed: _____

Records [ ] mailed [ ] picked up Number of pages:_____ Charge: _____