PRIMARY CARE
AT MEDICAL CENTER CLINIC

PLEASE FILL OUT FORM COMPLETELY

Patient Information:

Patient Name: _____ Medical Record #_____

Date of Birth: _____ SS#_____ Ph#_____

I hereby authorize _____to release the following

information contained in my medical record for treatment during the period from

_____ to _____ as follows:

[ ] All records *including* Confidential **[ ] All records *except* Confidential**

Confidential:
[ ] Mental Health [ ] Sexually Transmissible Disease(s) [ ] Substance Abuse [ ] Genetic Testing

Treatment Records:
[ ] All Patient Health Information [ ] Progress notes for Doctors [ ] Lab Reports [ ] X-ray Reports
[ ] Other (*Please Specify*) _____

Disclosure of patient's PHI TO : Sarah Skechak, APRN-C
8333 N. Davis Hwy
Pensacola, Florida 32514
Ph: 850.474.8200 Fax: 850.969.2297

X_____(INITIAL) I acknowledge that the records requested above may contain alcohol, drug abuse, mental health, sexually transmissible disease(s) (including HIV and AIDS), and genetic information, and herby consent to the disclosure of said information.

Expiration: This Authorization shall expire automatically one (1) year from date signed or upon:

[ ] Fulfillment of this request (according to HIPAA or State Regulations, whichever is shorter.)

[ ] Specific Date: _____

[ ] Yes [ ] No This authorization may be used to disclose PHI of the *same type* described above which may be *created in the future* until the expiration date.

I understand that by federal law, Medical Center Clinic (MCC) may not use or disclose PHI without authorization except as provided in MCC's Privacy Practices. By signing this Authorization, I am giving permission for the uses and disclosure of the described PHI. I hereby release MCC and its employees from any and all liability that may arise from the release of information as I directed.

- I understand that I have the right to revoke this Authorization at any time if I do so in writing and address it to the person or institution named above. I understand that the revocation will not apply to any actions already taken as a result of this authorization.

- I understand that I may refuse to sign this Authorization and that MCC and/or the providers named above cannot deny or refuse to provide treatment if I refuse to sign.

- I understand that information disclosed pursuant to this Authorization may no longer be protected by the federal medical privacy law and could be disclosed by the person or agency that receives it.

- I understand that I may be charged a fee of up to $1.00 per page (plus applicable tax and handling) for every page copied and that this fee is within the limits allowed by Florida law.

_____ _____

Patient/Legal Representative Signature **Date**

If signed by Legal Representative:

Relationship to Patient: _____ Legal Authority: _____

Verification of Identity: _____ Verification of Authority: _____