Authorization for Use or Disclosure of

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Office: 386-304-1181 | Fax: 386-304-6401

Protected Health Information

By signing this form, I authorize the following:

Information Is To Be Disclosed By / Provided To

Name of facility

Name of person / organization / facility

Address

Address

City / State

City / State

Phone number

Phone number

Purposes of Disclosure - check all that apply

- [ ] Further Medical Care
- [ ] Attorney / Litigation
- [ ] School
- [ ] Personal Use
- [ ] Insurance
- [ ] Disability
- [ ] At the Patient's request
- [ ] Other

Other purpose

Health Information To Be Disclosed - check all that apply

- [ ] Only information related to (specify)
- [ ] Only the period of events specified below
- [ ] Other (X-Rays, Billing, etc.)
- [ ] Entire Record

Related information

Period from

to

Other details

I hereby authorize the disclosure of information from my health record as described above. I understand that this authorization is voluntary; that the information to be disclosed is protected by law; and that use/disclosure is to conform to my directions. I understand that treatment, payment, enrollment, and eligibility for care are not conditioned upon providing this authorization except as may be necessary for claim review and appeal purposes.