Two Rivers Family Practice

1231 South Patrick Drive, Satellite Beach, FL 32937

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____SSN#:_____
Facility/Physician Name (where records will be coming from) _____
Facility/Physician Phone/fax/address _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The type of information to be used or disclosed is as follows (check appropriate boxes and include other information where indicated)

☐ History & Physical	☐ ER Record
☐ Discharge Summary	☐ Cardiology Reports
☐ Lab Results	☐ Physician Orders
☐ Radiology Reports	☐ Progress Notes
☐ Consultation Reports	☐ Entire Medical Record

☐ Other – Please specify below i.e., Vascular Lab, Pulmonary or other ancillary visits:_____

3. I understand that the health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV) *if applicable*. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse *if applicable*.
4. I authorize Two Rivers Family Practice to make the disclosure to the individual(s) or organization identified below:
5. The items identified above may be used or disclosed to the following individual(s) or organization(s):

Two Rivers Family Practice 321-622-5432 phone ~ Fax 321-622-8329
1231 S. Patrick Drive Satellite Beach, FL 32937

6. This information for which I am authorizing disclosure will be used for the following purpose:

☐ My personal records	☐ Continued Care – Specify Physician
☐ Legal Purpose	Physician Name: _____
☐ Insurance	Fax # 321-622-8329_____
☐ Other, Please describe	_____

7. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Two Rivers Family Practice. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
8. I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ _____
Signature of patient or legal representative Date