Authorization for Use or Disclosure of Protected Health information

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____, authorize the disclosure of information from my medical record.

Birthdate: _____SSN (Last 4 digits): XXX-XX-_____

II.

The information is to be disclosed by:	**And is to be provided/sent to:**
NAME OF FACILITY: **LoCicero Medical Group (FAX: 813-877-1277)**	NAME OF PERSON/ORGANIZATION/FACILITY:
ADDRESS: 110 S. MacDill Ave, Suite 300	ADDRESS:
CITY, STATE, ZIP: **Tampa, Florida, 33609**	CITY, STATE, ZIP:

III. Purpose or need for this disclosure is:

☐ **Continued Treatment** ☐ **Attorney** ☐ **School** ☐ **Research**
☐ **Personal Use** ☐ **Insurance** ☐ **Disability** ☐ **Other**_____

IV. Information to be disclosed from my medical record: (Check appropriate box(es))

☐ Only information Related to (specify)_____
_____
☐ Only for dates of service from_____to_____
☐ Only (specify) (ex: radiology, billing, etc.) _____
☐ Entire Record

V. If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral
☐ Sexually Transmitted Diseases
☐ HIV/AIDS Testing & Treatment
☐ Mental Health (Other *than Psychotherapy Notes*)
☐ Genetic Testing
☐ Sexual & Reproductive Health

VI. I understand that by signing this authorization, my Treatment, Payment and enrollment in a health plan or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

VII. I understand that the information disclosed may be subject to redisclosure by the person or entity receiving it and would then no longer be protected by federal privacy regulations.

VIII. I may revoke this authorization by notifying _____in writing of my desire to revoke it. However, I understand that any actions already taken based on this authorization cannot be reversed and my revocation will not affect those actions.

IX. This authorization expires on_____, 20_____, Or upon the following event:
_____.
If no date or event is specified, the authorization will automatically expire one (1) year from the signature date.

_____ _____
SIGNATURE OF PATIENT *DATE*

_____ _____
SIGNATURE OF PERSONAL REPRESENTATIVE & RELATIONSHIP TO PATIENT *DATE*

_____ _____
SIGNATURE OF WITNESS (If signature of patient is a thumbprint or mark) *DATE*