**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 | NAME OF PERSON/ORGANIZATION/FACILITY:<br>**LoCicero Medical Group (FAX: 813-877-1277)** |
| ADDRESS | ADDRESS:<br>110 S. MacDill Ave, Suite 300 |
| CITY, STATE, ZIP | CITY, STATE, ZIP:<br>**Tampa, Florida, 33609** |

**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
☐ Mental Health (Other *than Psychotherapy Notes*)
☐ Sexually Transmitted Diseases
☐ Genetic Testing
☐ HIV/AIDS Testing & Treatment
☐ 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*