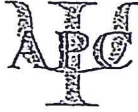

Authorization for Release of Medical Information
Pursuant to the Health Insurance Portability and Accountability Act (HIPAA), I

____ hereby authorize. The following individual or Organization is authorized to release the following.

____
(Name of someone whom you approve to have access to your records or Organization)

____
(Address)

____
(Telephone/Fax)

To use or disclose the following protected health information from my medical record as instructed by me:

[ ] The entire medical record [ ]Appointments [ ] Test results [ ] Pay for your office visits

[ ] Specific parts of the medical record [ ] Leave messages for Doctor or Therapists [ ] Speak with staff

[ ] Colbaration with organization for continued care or to set up continued care0 l

The information is to be disclosed to: Advanced Psychiatric Care PC, 9400 Gladiolus Drive, Suite 340, Fort Myers, fl. 33908

I understand that I may revoke this authorization, at any time, by writing to the Privacy Officer, at which time it will go into effect. I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. Unless otherwise revoked, this authorization will expire on 90 days, or ___________. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosures of the above information to the extent indicated and authorized herein.

I understand the information in my health record may include psychiatric, alcohol or drug abuse/testing information which may be protected by Federal and State Regulations. I also understand that my health record may include information relating to AIDS,HIV, and or sexually transmitted disease, and all other sensitive information.

If you would prefer NO ONE have access to your record please initial ________

I fully understand and accept the terms of this authorization.

_____________________________ ____________
Patient/Legal Representative Signature Date