Bay Area Medical Clinic

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT'S NAME:_____ DATE OF BIRTH:___/___/_____

I authorize the use or disclosure of the above named individual's health information as described below. The following individual or organization is authorized to make the disclosure:

DOCTOR'S NAME:_____
ADDRESS:_____
_____
PHONE NUMBER:_____
FAX NUMBER:_____

I hereby request and authorize the following information to be released from my medical records:

☐ ALL MEDICAL RECORDS ☐ MEDICAL RECORDS - PAST TWO (2) YEARS ONLY
☐ RADIOLOGY ☐ LABS ☐ CONSULT NOTES
☐ OTHER:_____

I understand that the information in my health record may include information including Sexually Transmitted Diseases, HIV screenings or results, and any mental health or substance abuse.

This information may be disclosed to and used by the following individual or organization:

Bay Area Medical Clinic, P.A.
37900 Daughtery Road, Suite 1
Zephyrhills, FL 33541
Telephone: 813-715-4446
Fax: 813-780-7786

The purpose for which this information is being released to the above individual or organization:

TO CONTINUE MEDICAL TREATMENT .

This authorization may be revoked at any time. Revocation will prevent subsequent release of information under this authorization. If not previously revoked, this authorization will expire in one (1) year. I understand that authorizing the disclosure of my health information is voluntary. I can refuse to sign this authorization. My treatment will not be refused by not signing this authorization. I understand that I may inspect or copy this information to be used or disclosed, as provided in CFR 164.524. I understand that if I have any questions regarding the disclosure of my medical information, I can contact Bay Area Medical Clinic, P.A. at (813) 715-4446.

Patient's Signature:_____ Date: ___/___/_____

Witness Signature:_____ Date: ___/___/_____

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