8976 Conroy Windermere Road
Orlando, Florida 32835
Telephone: 407-876-0073
Fax: 407-876-0078

PERSONALIZED PRIMARY CARE

AUTHORIZATION TO OBTAIN, RELEASE OR REVIEW PROTECTED HEALTH INFORMATION

Patient Name: _____ Phone #:_____-_____-_____

Address: _____ City: _____ State: _____ ZipCode: _____

SSN#:_____-_____-_____ Date of Birth_____/_____/_____

I hereby authorize **Personalized Primary Care** to use and ***disclose to:*** ☐ ***or obtain from***: ☐ ***or allow review***: ☐

Name of Facility or Person: _____

Phone #:_____---_____---_____ Fax #:_____---_____---_____

Address: _____ City: _____ State: _____ ZipCode:_____

the following information contained in my medical record regarding my care and treatment (please initial):

_____Complete Record ____All Diagnostic Test Results ____Pathology Report(s) ____Abstract of Record

_____Therapy Records ____Consultations ____Lab Only ____Radiology Only ____Operative Report

_____Progress note(s) ____Appointments ____Medications ____Other (please specify):_____

The purpose for the release of information at the request of the individual is:

☐ Continued Treatment: ☐ Legal Action: ☐ Insurance: ☐ Personal Use: ☐ Other (please specify): _____

This authorization will expire 1 year from the date signed unless otherwise stated: _____

I understand that this authorization extends to all or any part of the record designated above, which may include psychiatric information, and /or genetic counseling/testing, and/or alcohol/drug abuse and/or AIDS (acquired Immunodeficiency Syndrome), and /or may include the result of an HIV test of the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initialed below or otherwise required by law.

May **NOT** include information related to (please initial):

_____HIV/AIDS ____Mental Health ____Drug/Alcohol Abuse ____Genetic Counseling/Testing

I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that my protected health information is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that PERSONALIZED PRIMARY CARE may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization. I understand that I will receive a signed copy of this form upon request.

Patient/legal representative or Parent/Legal Guardian Signature: _____ Date: _____/_____/_____

Name of Person Witnessing Authorization Signature:_____ Date:_____/_____/_____