Harris Internal Medicine

5900 Turkey Lake Road, Suite A, Orlando, FL 32819
Phone: 407.351.9696 Fax: 407.351.8848

AUTHORIZATION TO OBTAIN, RELEASE OR REVIEW PROTECTED HEALTH INFORMATION

Patient Name: ______________________ Social Security #: ______________

Address: ____

Date of Birth: ____________ Date of Service: ____________ Phone #: ______________

I hereby authorize Harris Internal Medicine to use and **disclose to:** ☐ **or obtain from:** ☐ **or allow review:** ☐

____
Name of Facility or Person | Phone | Fax

____
Street Address | City | State | Zip Code

Send Records to: (Name of Facility or Person) ______________________

____
Street Address | City | State | Zip Code

the following information contained in my medical record regarding my care and treatment:
☐ Complete Record ☐All Diagnostic Test Results ☐ Lab Only ☐ Radiology Only

☐ Other (Please Specify) ______________________

The purpose for the release of information at the request of the individual is:
☐ Insurance ☐ Continued Treatment ☐ Personal Use ☐ Other (Please Specify)______________

This authorization will expire on the following date, event or condition: ______________
I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse and/or AIDS and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designed above unless initialed below or otherwise required by law.

May NOT include information related to:
☐ HIV/AIDS ☐ Mental Health ☐ Drug and/or Alcohol Abuse ☐ Genetic Counseling/Testing

If I fail to specify an expiration, event, or condition, the authorization will expire in one year. 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 that 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.

____
Patient/Legal Representative or Parent/Legal Guardian Signature | Date

For Official Use Only:

☐ Completed authorization form faxed ☐ Completed authorization form mailed Staff Initials/Date:
____

☐ **I wish to revoke this authorization.** Signature: Date: