Authorization to Use or Disclose Protected Health Information

WEST COAST INFECTIOUS DISEASES, PA

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Patient Name:	SSN:	DOB:	Date:
Name of Institution Holding Records			
Address:			
City, State, Zip:			

I AUTHORIZE YOU TO RELEASE RECORDS TO:

Name of Person/Institution Requesting Records	West Coast Infectious Diseases, PA
Address:	1840 Mease Drive, Suite 319
City, State, Zip:	Safety Harbor, Florida 34695 phone:727-669-6800 fax: 727-669-2540

REASON FOR RELEASING INFORMATION

Continued Care

PORTION OF MEDICAL RECORD TO BE RELEASED

☐ All Records ☐ Labs/X-rays ☐ Consult/Follow-up reports ☐ Geographic/Billing information

I AUTHORIZE YOU TO REGISTER ME WITH_____ SO I CAN OBTAIN A PIN NUMBER TO ACCESS MY LABORATORY DIAGNOSTIC TESTING RESULTS ONLINE: _____ _____
(SIGNATURE) **(DATE)**

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider; the released information may no longer be protected by Federal privacy regulations. I understand that I need not sign this authorization to ensure treatment. This authorization shall remain valid for six months from the date signed below or until revoked by in writing by me.

This information is released in good faith for a specific purpose. No copies of released information may be disclosed to anyone without additional written consent of the person to whom it pertains, unless specified in this authorization.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to West Coast Infectious Diseases. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

The undersigned hereby releases the above mentioned institution from any liability which may arise from release and/or examination of the information indicated above. I understand there is a charge for copies and that such charges must be paid prior to the release of records.

I understand that this will include all records relating to any diagnosis and/ or treatment of HIV and AIDS. By answering YES and by my signature below allows release of this protected health information. Please release all records relating to HIV tests results and/or AIDS diagnosis and treatment.

_____**YES** _____NO ***Signature***_____ **Date**_____

Signature of Patient or Legal Guardian:	Printed Name:	Date:
Reason Pt unable to sign:	Relationship:	
Witness Signature		Date