Authorization to Use or Disclose Protected Health Information

WEST COAST INFECTIOUS DISEASES, PA

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Phone: (727) 669-6800 Fax: (727) 669-2540

Patient Name:	SSN:	DOB:	Date:

Name of Institution Holding 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**

I AUTHORIZE YOU TO RELEASE RECORDS TO:

Name of Person/Institution Requesting Records	
Address:	
City, State, Zip:	

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

☐ HIV/AIDS ☐ Mental Health/ Emotional Health ☐ Substance Abuse ☐ Genetic information

By signing this form I understand that I am authorizing the designated medical records custodians or database custodian to use and/or disclose my protected health information (PHI) as defined under 45 CFR 164.501, the federal regulations implementing the Health Insurance Portability and Accountability Act of 1996 (1HIPAAI) as described below to the following person(s) or organization(s)

I understand that protected health information released to a third party pursuant to this form may be re-disclosed and may no longer be protected by state and federal law. I understand that I need not sign this authorization to ensure treatment. This authorization shall remain valid for one year 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 (1) Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV) infection; (2) treatment for drug or alcohol abuse; (3) mental or emotional health or psychiatric care By answering YES and by my signature below allows release of this protected health information. Please release all records relating to) Acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIVl) infection; (2) treatment for drug or alcohol abuse; (3) mental or emotional health or psychiatric care.

_____YES _____NO *Signature*_____ Date_____

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