OSTEOPATHIC
FAMILY WELLNESS CENTER

5555 E. Michigan St. Suite 103 Orlando, FL. 32822
(407) 456-2977 **FAX: 866-878-6632**

Authorization and/or Disclosure of Protected Health Information

Patient Name: _____ Today's Date: __ __ ____/____ ____/ ____ ____

Date of Birth: ____ ____/____ ____/____ ____ ____ ____ SSN: ____ ____ ____-____ ____-____ ____ ____ ____

Patient Address: _____

City: _____State: _____ Zip: _____-_____

Phone Number: ____ ____ ____-____ ____ ____-____ ____ ____ ____

I hereby request:

_____Release of my records by individual(s) specified below to 'OSTEOPATHIC Family Wellness Center.'

The Purpose of this request:

___ At my request
___Other: _____

The description of the specific protected health information to be accessed and/or disclosed:

My Medical Records for dates of service: ____ ____/____ ____/____ ____ --- ____ ____/____ ____ /____ ____

Include the following: (please initial)

_____Radiology Report(s) _____Consultation Pathology Report(s) _____History & Physical Operative Report(s)

_____Laboratory Report(s) _____HIV/AIDS _____Mental Health

_____Other (specify)_____

I authorize:

Name of Dr. or Facility and Address: _____

_____

_____

Phone #: ___ ___ ___-___ ___ ___-___ ___ ___ ___ FAX: ___ ___ ___-___ ___ ___-___ ___ ___ ___

…to disclose the protected health information specified above to:

Osteopathic Family Wellness Center
Dr. April Smith-Gonzalez
5555 E. Michigan St. Suite 103
Orlando, FL. 32822
(407) 456-2977

FAX: 866-878-6632

I have read and understand the following statements: (please initial)

____I understand that if I request a copy of the protected health information specified herein, 'OSTEOPATHIC Family Wellness Center' may impose a reasonable, cost-based fee for such access.

____I understand that if I am denied access to all or a portion of my protected health information, the protected health information that I have been denied access to may not be disclosed as authorized in this Form.

____I understand that the protected health information specified above may include mental health, substance abuse (e.g., drugs, alcohol) and/or HIV/AIDS status information and treatment records upon my request.

____I understand this form is revocable, upon written notice to 'OSTEOPATHIC Family Wellness Center' it will not have any effect on any actions 'OSTEOPATHIC Family Wellness Center' took before it received the revocation. Unless otherwise revoked, this authorization will expire ninety (90) days from the date signed.

____I understand that my authorized disclosure of protected health information to the individual specified above carries with it the potential for re-disclosure by such individual and may no longer be protected by the Federal privacy laws.

____I understand that signing this form is completely voluntary and I am signing it under my own free will. I understand that 'OSTEOPATHIC Family Wellness Center' will not condition treatment, payment, enrollment in any health plans or my eligibility for benefits if I decide not to sign this Form.

____By signing this Form, I hereby authorize and permit the use and/or disclosure of my protected health information for the limited purposes(s), and in the limited manner, described in the Form.

____I understand I will receive a signed copy of this Form upon request.

If this form authorized the use and/or disclosure of psychotherapy notes, it may not be used to authorize the use and/or disclosure of any other protected health information.

Please read carefully before initialing:

_____I am the patient and I understand and agree to the provisions of this form/authorization.

_____I understand and agree to the provisions of this form **on behalf of the individual indicated below to be the patient**. I have signed my name individually and in my capacity as the **legal representative** of the patient and I have attached a copy of the **court order designating** me as the **guardian** of the patient, or documentation designating me as the **legal representative for the patient**.

Printed Name of Patient: _____ Patient's Signature: _____

Printed Name of Legal Representative_____ Legal Representative's Signature_____

Printed Name of Witness_____ Witness' Signature: _____