CARINE FAMILY MEDICINE

1811 SHORE DRIVE SOUTH - SOUTH PASADENA - FLORIDA - 33707 - PHONE 727.391.4100 - FAX 727.398.2067

Authorization to Disclose Confidential Information

Information to be disclosed by:

Person/ Facility:____

Phone #: _________________________________ Fax #: ____

Address:____

Information may be disclosed to:

CARINE FAMILY MEDICINE

Address: 1811 SHORE DRIVE SOUTH, SOUTH PASADENA, FLORIDA 33707

Phone: 727.391.4100 Fax: 727.398.2067

Method of disclosure:

- ☐ Pick up at clinic/facility
- ☐ Fax #: ________________________
- ☐ Address: ____
- ☐ Email address: (please note that emailing may not be a secured method of communication): ____

Information to be disclosed:

- ☐ General Medical Record(s)
- ☐ Immunizations
- ☐ Progress Note(s)
- ☐ STD records
- ☐ Family Planning
- ☐ TB records
- ☐ Prenatal Records
- ☐ History and Physical Results
- ☐ Consultations
- ☐ Diagnostic test reports
- ☐ All records

I specifically authorize release of information relating to:

- ☐ HIV test results
- ☐ Substance abuse service provider client records
- ☐ Psychiatric, Psychological or Psychotherapeutic Notes
- ☐ Early Intervention
- ☐ WIC

Purpose of disclosure:

- ☐ Continue of Care
- ☐ Personal Use

Other (specify)___________________________________

Expiration Date: This authorization will expire 12 months from the date on which it was signed.

Redisclosure: I understand that once the above information is disclosed, I may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

Conditioning: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sing this form.

Revocation: I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation to the medical record department. 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, Medicaid or Medicare.

Patient / Legal Representative Name:___(Print Name)____

Signature: _______________________________________Date:_________________________