

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:

CARINE FAMILY MEDICINE

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

Phone: 727.391.4100 Fax: 727.398.2067

Information may be disclosed to:

Person/ Facility: _____

Phone #: _____ Fax #: _____

Address: _____

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:

- | | | |
|--|---|--|
| <input type="checkbox"/> General Medical Record(s) | <input type="checkbox"/> Family Planning | <input type="checkbox"/> Consultations |
| <input type="checkbox"/> Immunizations | <input type="checkbox"/> TB records | <input type="checkbox"/> Diagnostic test reports |
| <input type="checkbox"/> Progress Note(s) | <input type="checkbox"/> Prenatal Records | <input type="checkbox"/> All records |
| <input type="checkbox"/> STD records | <input type="checkbox"/> History and Physical Results | |

I specifically authorize release of information relating to:

- | | | |
|--|--|---|
| <input type="checkbox"/> HIV test results | <input type="checkbox"/> Psychiatric, Psychological or Psychotherapeutic Notes | <input type="checkbox"/> Early Intervention |
| <input type="checkbox"/> Substance abuse service provider client records | | <input type="checkbox"/> 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 sign 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: _____

