



Family Health Centers
OF SOUTHWEST FLORIDA, INC.

Authorization for Release of Protected Health Information as Required by the
Health Insurance Portability and Accountability Act of 1996
(To be completed by the patient or the patient's authorized representative:)

Patient's Name DOB Chart#

Street Address City State Zip Code

Telephone Fax no.

I hereby authorize:

[] Family Health Centers of Southwest Florida, Inc., or

[] Name of Physician or Provider

Street Address City State Zip Code

Telephone Fax no.

To release my confidential health information, as described below, to:

[] Me [] The staff at Family Health Centers of Southwest Florida, Inc., or

[] Name/Organization Name

Street Address City State Zip Code

Telephone Fax no.

In the following manner:

[] Mail [] Fax [] To be picked-up [] Other:

My authorization is for the use and disclosure of the following records:

You must INITIAL next to each record requested: (If applicable)

- Statements of charges and payments
Records of Family Health Centers of Southwest Florida, Inc. visits
Mental health records
Dental records
X-rays and other images
AIDS or HIV information STD/Communicable Diseases
Drug and / or Alcohol
Other:
All of the above

For information generated on the following date: _____
My authorization is given freely with the understanding that:

- I may refuse to sign this authorization.
- I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that my revocation is in writing.
- Family Health Centers of Southwest Florida, Inc. may not condition my treatment, payment, and enrollment in a health plan, or eligibility for benefits on my provision of this authorization.
- This authorization is valid for a _____ day period from the date it is signed or sooner if so specified by me, as indicated below.
- A photocopy or fax of this authorization is as valid as the original.
- Family Health Centers of Southwest Florida, Inc., its directors, officers, employees, agents and volunteers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I will be given a copy of this signed authorization if the authorization is at the request of Family Health Centers of Southwest Florida staff.

This authorization will expire on: _____

Patient's Signature _____
Date

Name of Parent or Personal Representative Signature (please print) _____
Date

Description of Legal Authority to Act on Behalf of Patient

Patient's Acknowledgement of Receipt

To be completed by the patient, the patient's personal representative or other person designated in the authorization to receive the requested protected health information when the patient, representative or other person appears at Family Health Centers of Southwest Florida, Inc. in person to receive the information.

I hereby acknowledge that I have received the above requested health information:

Name (please print) _____

Signature _____
Date

This information is to be disclosed for the purpose of _____

Are you leaving the practice ____ Yes No ____

Reason for transferring from Family Health Centers: _____