Treatment, Surgery & Rehabilitation of the Hand & Wrist

Authorization to Disclose Protected Health Information (PHI)

Release Information **FROM:**

Name: ______________________________

Address: ______________________________

____

____

Phone: ______________________________

Fax: ______________________________

Release Information TO:

Tampa Bay Hand Center, P. A.
13905 Bruce B. Downs Boulevard
Suite B
Tampa, FL 33613

Phone: 813-978-9494
Fax: 813-979-4817

I authorize the above listed person/entity to disclose my PHI as follows:

Patient's Full Name: ______________________________ DOB:____/____/______ SSN/Medical Record #: ________________

Address: ______________________________

Covering the period of healthcare from: ____/____/______ to: ____/____/______

1. Information authorized for disclosure, if included in my records:

- ☐ Complete Health Record
- ☐ Visit/Discharge Summary
- ☐ Laboratory Tests
- ☐ Pathology Reports
- ☐ Immunization Records
- ☐ Progress Reports
- ☐ Radiology/Diagnostic Imaging Reports
- ☐ Photographs/Videos/Digital or Other Images
- ☐ Documentation of Consultation
- ☐ Clinical Documentation of Physical
- ☐ Other ________________________ ________________________________

2. If applicable, I also give permission for the following "Sensitive Protected Health Information" to be disclosed:

- ☐ Acquired Immunodeficiency Syndrome (AIDS) or Infection with Human Immunodeficiency Virus (HIV)
- ☐ Behavioral Health Services / Psychiatric Care
- ☐ Treatment for Alcohol and/or Drug Abuse
- ☐ Sexually Transmitted Diseases (STD)
- ☐ Genetic Counseling / Testing

I understand that the information disclosed pursuant to this authorization, except information protected by Federal/State regulations about confidentiality of drug/alcohol abuse records, HIV and mental health, may be subject to redisclosure by the recipient, no longer protected by federal privacy regulations or other applicable state and federal laws.

3. I understand I have a right to revoke this authorization at any time and I must do so in writing and present my written revocation to the provider(s) of care. I understand that the revocation will not apply to information that has already been released in response to this authorization and will not apply to my insurance company when the law provides my insurer with the right to review or contest a claim. Unless otherwise revoked, this authorization will expire on the following date, event, or condition ____/____/____. If I fail to specify an expiration date, event, or condition, this authorization will expire in 90 days. If this authorization pertains to oneself as the patient, the expiration date can be documented as unlimited. If documented as such, (Initial here ______).

4. I understand any disclosure of PHI carries with it the potential for unauthorized and future re-disclosures, as allowed by HIPAA and other federal privacy rules. If I have questions about disclosures of my PHI, I can contact my provider of care.

5. This facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

____

Patient/Patient Representative Signature | Relationship to Patient | Date

____

ID Provided | Name/Title of Person Releasing Information | Date