Tampa Bay Hand Center

As required by HIPAA, this facility may not use or disclose your protected health information, except as provided in our Notice of Privacy Practices, without your authorization.

I hereby authorize Tampa Bay Hand Center, P.A. and any of its employees to use or disclose my protected health information (PHI) to the following person(s) or entity:

_____

_____

_____

PHI authorized to be disclosed:_____

_____

_____

Effective dates for this authorization are _____/_____/_____ through _____/_____/_____
This authorization will expire at the end of the above-designated time period.

I understand that information disclosed under this authorization may be disclosed again by the person(s) or entity to which it is provided. It may not be possible to ensure your right to the protection of the privacy of this information once Tampa Bay Hand Center, P.A. disclosed it to another party.

I understand I have the right to:

1. Revoke or terminate this authorization by submitting a written revocation to Tampa Bay Hand Center, P.A. Revocation will not affect previously disclosed PHI.
2. Inspect a copy of PHI being disclosed under this authorization.
3. Refuse to sign the authorization.
4. Receive a copy of this authorization.
5. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this authorization, it will not condition my treatment, payment, enrollment, or eligibility for benefits.

_____	_____	_____
Patient/Patient Representative Signature	Relationship to Patient	Date