524 Zeagler Drive
Palatka, Florida
(386) 385-3857 fax (386) 530-2052
HyperbaricsPalatka@gmail.com
NPI#1518518042

AUTHORIZATION

FOR RELEASE OF PROTECTED HEALTH INFORMATION

I,_____, D/O/B_____, authorize the use and disclosure of my protected health information as described below.

I understand that my protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I authorize any current or past medical professional, medical care institution, pharmacy or other medical caregiver that has treated me or provided medical services or supplies to me to disclose my protected health information to **Hyperbaric Health Services – Palatka.**

The protected health information that may be used and disclosed is as follows:

Medical records or any information concerning my current or past health status or treatment received from my medical care providers.

I understand that Hyperbaric Health Services - Palatka will use and disclose my protected health information for the following purposes: **For treatment of my medical condition**.

I understand that Hyperbaric Health Services - Palatka will not condition my treatment on this authorization.

I understand that I may revoke this authorization at any time by sending a written notification addressed to**: Hyperbaric Health Services – Palatka, 524 Zeagler Drive, Palatka, Florida 32177**, and this revocation will be effective for future uses and disclosures of protected health information. However, I further understand that this revocation will not be effective for information that Hyperbaric Health Services - Palatka already has used or disclosed.

This authorization expires 30 months from the date of signature.

_____ _____
Signature of Patient or Personal Representative Date

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

Please return to HHSP via fax, email or delivery.