CORAL SPRINGS
PRIMARY CARE

AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORDS

In accordance with the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder governing the privacy of health information, this notice informs you of the purpose of the form and how it will be used.
PRINCIPAL PURPOSE(S): This form is to provide Coral Springs Primary Care with a means to request the use and/or disclosure of an individual's protected health information.
ROUTINE USE(S): To any third party or the individual upon authorization for the disclosure from the individual, **within 3 to 5 BUSINESS days**, for: personal use; insurance; treatment or continued medical care; school; legal; retirement/separation; or other reasons as specified below.
DISCLOSURE: Voluntary. Failure to sign the authorization form will result in the non-release of the medical records.

Client Name: _____ **DOB** _____

☐ I am the client and hereby authorize the use or disclosure of health information, including protected health information, about me as described below.
☐ I am the client's representative and understand and agree to the provisions of this authorization on behalf of the client. My authority to act on behalf of the client is as follows: _____

By signing this form, I authorize the release of health information, including protected health information. I authorize PrimeCare North to:

☐ **disclose to**	☐ **obtain from**
Please enter Provider name & contact information	*Please enter Provider name & contact information*

INFORMATION MAY BE DISCLOSED BY: PrimeCare North and any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf.

INFORMATION TO BE DISCLOSED: (Initial Selection)

_____ General Medical Record(s), including TB _____ Progress Notes _____ Consultations _____ History and Physical Results
_____ Immunizations _____ Family Planning _____ Prenatal Records _____ Diagnostic Test Reports
Specify Type of test(s): _____
_____ Other: _____ Specify dates of service: _____

By applying a check next to a category of highly confidential information listed below and signing on the appropriate line after the checked box, I specifically authorize the disclosure of the type of highly confidential information indicated next to my signature.

☐ DNA/Genetic Testing _____
☐ Mental Health Records _____
☐ Sexual Assault _____
☐ Sexually Transmitted Disease _____
☐ Alcohol/Substance Abuse Service Provider Client Records _____
☐ Psychologist/Psychotherapeutic Notes and Records _____
☐ Marriage/Family Therapist or Clinical Social Worker Records _____
☐ Child Abuse or Neglect/Early Intervention _____
☐ Confidential HIV-Related Health Information _____

PURPOSE OF DISCLOSURE:
☐ Treatment ☐ Personal Use ☐ Billing/Payment ☐ Continuity of Care ☐ Other (specify) _____

EXPIRATION DATE: This authorization will expire (insert date or event) _____. I understand that if I fail to specify an expiration date or event, this authorization will expire twelve (12) months from the date on which it was signed.
REDISCLOSURE: I understand that once the above information is disclosed, it 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 and that treatment, payment, enrollment, or eligibility for benefits cannot be conditioned on whether I sign this authorization.
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 and Medicare.
FEES FOR COPIES: I understand that federal and state laws permit certain fees to be charged for the copying of patient records and that I may be charged fees in accordance with such laws.

I request and authorize the disclosure of information described above.

Patient/Guardian/Caregiver Signature _____ Date _____

Printed Name Patient/Guardian/Caregiver _____ Relationship to Client _____

Witness (optional) _____ Date _____