John Ness, MD, PA.
Dr. Ness Family Practice
616 Universal Drive, Tallahassee, FL 32303
Office 850-385-1839 | *Fax* 850-386-8371

COMMUNICATION DIRECTIVE FORM

PATIENT NAME: _____

LAST FIRST MIDDLE

DATE OF BIRTH: _____ LAST 4 OF SSN: _____

PHONE: _____

PLEASE INITIAL:

_____I AUTHORIZE JOHN NESS, MD, PA TO RELEASE OR VERBALLY DISCLOSE MY PROTECTED HEALTH INFORMATION (PHI) FROM MY MEDICAL RECORDS OR BILLING RECORDS RELATING TO MY IDENTITY, DIAGNOSIS, PROGNOSIS, OR TREATMENT.

_____I UNDERSTAND THAT THE EXTENT OR NATURE OF THE MEDICAL INFORMATION TO BE RELEASED INCLUDES ANY AND ALL MEDICAL RECORDS, INCLUDING, MENTAL, HEALTH, ALCOHOL, AND/OR SUBSTANCE USE DISORDER TREATMENT AND HIV/AIDS TESTING, TREATMENT OR DIAGNOSIS.

_____ I ALSO UNDERSTAND THAT THE PURPOSE OR NEED FOR THIS RELEASE IS TO ASSIST IN COMMUNICATION OF MY MEDICAL CARE. FURTHERMORE, I UNDERSTAND THAT THIS RELEASE MAY BE CANCELLED. IT WILL REMAIN IN FORCE UNTIL SUCH TIME AS IT IS CANCELED BY MYSELF.

_____ **I UNDERSTAND THIS IS FOR VERBAL INFORMATION AND DOES NOT AUTHORIZE THE RELEASE OF MEDICAL RECORDS** WHICH REQUIRES A SEPARATE AUTHORIZATION.

Specific Information to be Released:

- ☐ Immunization record, **current year** medical record (s), current **one year** of laboratory test results, and all X-ray and diagnostic study results.
- ☐ Immunization Records
- ☐ I **DO / DO NOT** authorize release of records pertaining to mental health evaluation or treatment.
- ☐ I **DO / DO NOT** authorize release of only records listed: _____

PROHIBITION OF DISCLOSURE: THE PROTECTED HEALTH INFORMATION TO BE RELEASED IS CONFIDENTIAL. THE DIRECTIVE DOES NOT AUTHORIZE JOHN L. NESS, MD TO RELEASE THIS INFORMATION TO ANY OTHER PARTY.

1.	NAME OF PERSON	RELATIONSHIP	PHONE
2.	NAME OF PERSON	RELATIONSHIP	PHONE
3.	NAME OF PERSON	RELATIONSHIP	PHONE

SIGNATURE OF PATIENT / GUARDIAN (RELATIONSHIP) DATE

***CANCELLATION**: I hereby revoke the designation of listed individuals to receive protected health information:

PATIENT SIGNATURE: DATE