Authorization to Use or Disclose Protected Health Information

I hereby authorize Dr._____to use or disclose the following information from the heath records of the individual whose name is described below.

Dr Phone #..... **Dr Fax #**_____

Patient Name: _____ DOB: _____

Address: _____

(CITY) (STATE) (ZIP)

I authorize the above named facility(s) to release medical, mental, alcohol, and/or drug abuse, HIV(human immunodeficiency virus) testing, AIDS, eating disorders or any other medical information of a sensitive nature to the following individuals or organization(s):

Howard Feingold, M.D. ● Marci Johns, ARNP ● Michael Wanger, M.D.
516 Lakeview Rd., Suite 4,
Clearwater, FL 33756
Phone: (727) 461-7908 ● Fax: (727) 223-5269

- This information for which I'm authorizing disclosure will be used for the following purpose:

Description:

_____

Dates of service to be released:

_____

The type of information to be used or disclosed is as follows (check the appropriate boxes and include other information where indicated)

☐ Abstract	☐ Progress Notes
☐ Discharge Summary	☐ Lab Results / X-Ray and all Imaging Reports
☐ History and Physical Reports	☐ Emergency Room Records
☐ Consultation Reports	☐ Other: _____

I understand that if the organization authorized above to receive the information is not a health plan or healthcare provider; the released information may no longer be protected by Federal privacy regulations. I understand that I need not sign this authorization to ensure treatment. This authorization shall remain valid for six (6) months from the date signed below. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the department or facility(s) listed on the authorization. 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 when the law provides my insurer with the right to contest a claim under my policy.

Signed: _____ **Date:** _____

Patient or Authorized Person, Parent ( ) Legal Guardian ( ) Executor ( ) Power of Attorney ( ) **( ) Photo ID Checked**

Witness: _____ **Date:** _____

Copied By: _____ **Date:** _____ **Pages Copied:** _____