6416 Old Winter Garden Rd.
Orlando, FL 32835
PH: 866-222-0403

HIPAA Privacy Authorization Form

I, _____ _____ , give permission to: _____
Patient Name Date of Birth Name of Facility

To disclose and release my Protected Health Information (PHI) to the following individual(s):

Name	Address, City, State, Zip and Telephone	Relationship

I authorize the release of PHI for the following timeframe:

From _____ To: _____ -OR- ☐ All past and future dates
Start Date End Date

The following PHI can be disclosed (check all that apply):

☐ My complete health records (including: mental health, communicable diseases, HIV or AIDS, treatment of alcohol/drug abuse, diagnosis, lab tests, prognosis, treatment, and billing for all conditions)

☐ My complete health records, as above, with the exception of the following information (check all that apply)

- ☐ Mental health records
- ☐ Alcohol/drug abuse treatment
- ☐ Genetic counseling/Testing information
- ☐ Communicable diseases (including HIV, AIDS and STD)
- ☐ Other: _____

FPG Family Physicians Group | Partners in Primary Care.

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Patient's Name: _____ DOB: _____

I understand the following:

- This authorization is valid for information already in my medical record and any information added while this authorization is effective.
- Authorizing this disclosure of information is voluntary and I can refuse to sign
- I may request to see this information during normal business hours.
- I do not have to sign this form to receive treatment.
- I can withdraw my approval by completing the **Revocation of Authorization** form at any time. The **Revocation of Authorization** form does not apply to:
  - Information that has already been released during this authorization.
  - My insurance company when the law provides my insurer the rights to contest a claim under my policy
- This medical information may be used by the persons I authorize to receive this information for:
  - Medical treatment or consultation
  - Billing or claims payment
  - Other purposes as I may direct
- If the persons or organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations. However, there may be other federal state laws that require the information to remain confidential.

Unless otherwise revoked, this authorization will expire **12 months** following the date of signature. I acknowledge that I have read this form or it has been read to me and I understand its content.

Signature _____ **Date** _____

Relationship to Patient:
If signed by a person other than yourself, please check the relationship and provide proof of authority.

☐ Self ☐ Legal Representative* ☐ Parent of Minor Child ☐ Other (specify)

_____ _____
****Name of Interpreter/Translator (If Required)** **Telephone**

***If signed by a person other than yourself, please check the relationship and provide proof of authority to do so.**
****If a translator or interpreter was required.**

OFFICE USE ONLY

_____ _____ _____
Office Personnel Name (Print) Signature Date