Florida Medical Clinic
Your life. Our specialty.

PATIENT AUTHORIZATION TO USE / DISCLOSE PROTECTED HEALTH INFORMATION

Name		Last 4 SSN	
Account #		Date of Birth	
Street Address			
City/State		Zip Code	

I authorize Florida Medical Clinic, PA to share the health information listed below to the following person, group, or entity

Name	Fax #/Mailing Address
1.	1.
2.	2.

Requesting Records for Self

Method:	Mailing address/Fax number/E-mail address
☐ Mail	
☐ Fax	
☐ Email	

Please select the type of information to be used or disclosed (include dates where appropriate)

☐ Entire record	☐ Laboratory results
☐ Medication list	☐ X-ray and imaging reports
☐ Problem list	☐ Consultation reports from _____
☐ List of allergies	☐ Visits/encounters: _____
☐ Immunization records	☐ Records from non-FMC providers
☐ Most recent history and physical	☐ Other(specify):
☐	

I authorize Florida Medical Clinic, PA to also share the following to the entity listed above. By not selecting any of the options below, I understand this information will not be shared.

☐ Treatment for Alcohol or Drug use/abuse	☐ Mental Health information (excluding psychotherapy)
☐ Sexually Transmitted Diseases/HIV-Related Information	☐ Psychotherapy
☐ Genetic	☐ Other

This authorization for release of information covers the period of healthcare services rendered from:

☐ _____ -	☐ All past, present, and future periods

Unless otherwise revoked, this authorization will expire on the follow date, event, or condition. If no date is specified, I understand this authorization will expire one year from the date below.

☐ Expiration date:	☐ Automatic expiration after one year

I understand the information in my health record may include information relating to sexually transmitted disease and other reportable disease, AIDS/HIV. It may also include psychiatric or mental health services, and treatment for alcohol and drug abuse. By not selecting any of these options above, I understand sexually transmitted diseases, mental health, and drug abuse will not be disclosed.
I have the right to revoke this authorization at any time by contacting Florida Medical Clinic, PA. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
I understand signing this authorization is voluntary. I do not need to sign this form in order to receive treatment.
I understand I may inspect or copy this information to be used or disclosed, as provided in CFR 164.524.
I understand that any disclosure of information carries with the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
I understand there is a fee for obtaining medical records and I agree to pay for such charges.
If I have any questions about disclosure of my health information I can contact Florida Medical Clinic's Privacy Officer at (352) 567-0188.

Signature:	Date:
Print Name:	Signature by: ☐ Patient ☐ Legal Guardian ☐ Proxy

To obtain a copy of your medical records, you may submit this form to FMC's Medical Records Department

Email: HPROI@floridamedicalclinic.com	Fax: (813) 355 - 5896
Mail: 2150 Via Bella Blvd Land O Lakes FL 34639	In person at your provider's office

Revised 08/02/2017