Central Florida Rheumatology Consultants, LLC

Authorization for disclosure of PHI to Families/Legal guardian

I AUTHORIZE THE USE / DISCLOSURE OF HEALTH INFORMATION ABOUT ME AS DESCRIBED BELOW:

Patient Name: _____

Patient's Date of Birth: _____ Patient's SSN: _____

A. Person(s) or Organization(s) authorized to provide the information: Central Florida Rheumatology Consultants , LLC

B. Person(s) authorized to receive the information/instructions/results pertaining to your treatment:

1. _____ DOB _____
2. _____ DOB _____
3. _____ DOB _____
4. _____ DOB _____

C. Specific description of the information that may be used or disclosed (including date(s)):

D. Specific description of how the information will be used: To assist with the plan of treatment between the above listed patient and the Rheumatology Clinic.

E. Authorization to leave results and messages regarding appointments and care, with family members listed above or on Voicemail. Please circle: _____YES or _____NO

1. I understand that this authorization will **expire** on _____.
2. I understand that I may **revoke** this authorization (except to the extent that action was already taken in reliance on this signed authorization) at any time by notifying cardiac clinic in writing.
3. I understand that I can **refuse to sign** this authorization and that my refusal will not affect my ability to obtain treatment, payment or my eligibility for benefits (if applicable).
4. I may **inspect or copy** any information used or disclosed under this agreement.
5. I understand that if the person or organization that receives the information is not a health care provider or plan covered by federal privacy regulations, the information described above may be redisclosed and would no longer be protected by these regulations.

_____ _____

Patient's Signature or Patient's Representative Date

_____ _____

Printed Name of Patient's Representative Relationship to Patient

NOTE:

You have the right to know specifically what information you are authorizing for release *(e.g., "results of a lab test performed on1/4/03" or, if your entire medical record is included, "all health information.").*

You have the right to know the name(s) or other identification of the person(s) or organization(s) authorized to release the information *(e.g., the names of your health care provider(s)).*

You have the right to know who is going to use it and what it is going to be used for. *(e.g., John Smith, PhD / Research).*

YOU HAVE THE RIGHT TO RECEIVE A COPY OF THIS FORM

HIPAA Authorization for Release of Information

This form does not constitute legal advice and covers only federal, not state, laws.