



Release of Protected Health Information

Patient Name: _____ DOB: _____

Previously known as: _____ Medical Record #: _____

I hereby authorize the release of my Protected Health Information (PHI) from: The Reproductive Medicine Group

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> 5245 E Fletcher Ave Suite 1 Tampa, FL 33617 Phone: (813) 914-7304 Fax: (813) 914-7314 | <input type="checkbox"/> 2919 Swann Ave Suite 305 Tampa, FL 33609 Phone: (813) 870-3553 Fax: (813) 872-8727 | <input type="checkbox"/> 3165 McMullen Booth Rd Suite F2 Clearwater, FL 33761 Phone: (727) 724-0702 Fax: (727) 724-1923 | <input type="checkbox"/> 612 Medical Care Dr. Brandon, FL 33511 Phone: (813) 661-9114 Fax: (813) 661-8337 |
|--|---|---|--|

For the purpose of: Continuity of care Personal Records Transferring Out of Practice
 Other, specify: _____

You may disclose the following Protected Health Information: Complete Medical Records
 Progress Notes Laboratory Reports Pathology Reports Surgical Reports
 Other, specify: _____

HIV, Mental Health and Drug & Alcohol Information contained in my medical record will NOT be released WITHOUT my authorization.

I authorize the disclosure of: HIV Mental Health (Psychiatric) Drug & Alcohol – **Patient Initials:** _____

Please mail records to

This authorization ends: On date: _____

This authorization will expire automatically when the records requested on this form have been mailed to the requestor or within 180 days from the date of signature, which ever comes first.

The Reproductive Medicine Group reserves the right to charge a fee for copying medical records. The practice will provide the first copy of medical records to the patient in any 12 month period at no charge. It is our policy to release records directly to the patient. Records will be mailed within 7 working days from the date of receipt of a properly executed Release of Protected Health Information authorization.

PATIENT RIGHTS: I understand I do not have to sign this authorization in order to receive health care services. However, I do have to sign an authorization form when the purpose is to provide my Protected Health Information (PHI) for a third party.

I understand that I may revoke this authorization in writing at any time by submitting a written letter to the named practice listed above. If I do, it will not affect any actions already taken.

I understand that once my Protected Health Information (PHI) has been disclosed to the named person/organization in this authorization, Privacy laws may no longer protect it, and the named person/organization may re-disclose it.

Patient or Legal Representative Signature

Date Signed

Print Name if signed on behalf of the patient

Relationship to Patient