



## Release of Protected Health Information

<b>Patient Name:</b> _____	<b>DOB:</b> _____
<b>Previously known as:</b> _____	<b>Medical Record #:</b> _____

I hereby authorize the release of my Protected Health Information (PHI) from:

**Name of Organization:** \_\_\_\_\_

**Organization Address:** \_\_\_\_\_

**Organization Phone#:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_

**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 send records to: The Reproductive Medicine Group**

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

**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