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:

Name: ______________________

Address: ______________________

____

Phone#: ______________________ **Fax #:** ______________________

For the purpose of: ☐ Continuity of care ☐ Personal Records ☐ Transferring Out of Practice ☐ Display photographs

☐ 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

☐ 5245 E Fletcher Ave
Suite 1
Tampa, FL 33617
Phone: (813) 914-7304
Fax: (813) 914-7314

☐ 2919 Swann Ave
Suite 305
Tampa, FL 33609
Phone: (813) 870-3553
Fax: (813) 872-8727

☐ 3165 McMullen Booth Rd
Suite F2
Clearwater, FL 33761
Phone: (727) 724-0702
Fax: (727) 724-1923

☐ 612 Medical Care Dr.
Brandon, FL 33511
Phone: (813) 661-9114
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 within180 days from the date of signature, which ever comes first.

RELEASE TO DISPLAY PHOTOGRAPHS: **Patient Initials:** _____

By signing below, I authorize the use of my child/children photographs to be displayed in The Reproductive Medicine Group facilities.

I understand all photographs provided to The Reproductive Medicine Group shall be displayed until revocation is received. I understand that I may revoke this authorization in writing at any time by contacting the office or by submitting a written notification to The Reproductive Medicine Group.

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) to 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