

PHYSICIANS' PRIMARY CARE OF SOUTHWEST FLORIDA, P.L.

___ 9350 Camelot Drive
Fort Myers, FL 33919
239-481-5437
Fax: 239-481-0570

___ 1261 Viscaya Pkwy. Ste. 101
Cape Coral, FL 33990
239-573-7337
Fax: 239-574-5883

___ 5624 8th Street W. Ste. 108
Lehigh Acres, FL 33971
239-368-7050
Fax: 239-368-1331

Authorization For Release Of Medical Information

Patient Name _____ DOB _____

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 [45 C.F.R. 164.508]. It authorizes Physicians' Primary Care of Southwest Florida, P.L. to disclose certain protected health information about me.

Check and/or specifically describe the information to be used or disclosed:

___ Complete health record _____
___ Specific dates of service _____
___ Specific conditions _____

I authorize the information to be released to:

I authorize _____ to release my medical information.

(Name and address of previous medical provider)

This information is to be disclosed or used for the purpose of:

This authorization will be in force and in effect until _____ at, which time this authorization, expires.

I understand that this WILL NOT include the following information unless indicated and initialed below:

___ Initials _____	AIDS or HIV infection
___ Initials _____	Behavioral health care/mental health services
___ Initials _____	Sexually Transmitted Disease information
___ Initials _____	Treatment for alcohol and/or drug abuse

Are you leaving the practice? ___ Yes ___ No

Reason for transfer of records: _____

Physicians' Primary Care will not condition my treatment, payment, or enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected under the federal HIPAA Rule. I may revoke this authorization at any time, except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted in writing to the Site Supervisor, at the address listed above.

Signature of Patient or Legal Representative _____ Date _____ Relationship to Patient _____