

Central Florida Pulmonary Group, P.A.

Patient Authorization for Use and Disclosure of Protected Health Information

Patient Name	Birth Date	Social Security Number
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By signing this authorization, I authorize *Central Florida Pulmonary Group, P.A.* to **obtain/release** certain protected health information (PHI) about me from/to: *(Name and address of entity being asked to release information or the entity to whom the information will be forwarded)*

The information requested to be obtained from the entity listed above should be sent to:

Attention: Medical Records, Central Florida Pulmonary Group, 326 North Mills Avenue, Orlando, Florida 32803

This authorization permits the following individually identifiable health information about me to be **obtained/released** for the specified date or period:

Records obtained/released are for the date(s) of _____ or the period from _____ to _____ (Date entry or period time **MUST** be entered)

- Visit services provided to me by any physician or other practitioner within the entity named above
- Visit services provided by only the following physician(s) or other practitioner(s) _____
- Office/Outpatient Diagnostic Testing Medication Lists Laboratory Results
- Psychiatric evaluation(s) and treatment Alcohol and/or drug abuse HIV testing/diagnosis
- Operative reports for surgical services Other _____
- My complete medical record _____

The information will be used or disclosed for the following purpose: _____ This authorization will expire: _____

I do not have to sign this authorization as a condition for receiving treatment from *Central Florida Pulmonary Group, P.A.* unless there is a specific rule under the federal Privacy Regulations where conditioning is permitted. If conditioning is permitted for this specific authorization, it is disclosed below including consequences that may apply. **Conditioning applies to this authorization: Yes No**

I understand that by refusing to sign this authorization, the following consequences may apply: *(This section is only completed when conditioning applies)*

When information about me is used or disclosed pursuant to this authorization, I understand it may be subject to re-disclosure by the recipient and may no longer be protected by the federal Privacy Rule.

I have the right to revoke this authorization, **in writing**, except to the extent that the practice has acted in reliance upon this authorization.

My written revocation must be submitted to the Privacy Officer at:

Central Florida Pulmonary Group, P.A., 326 North Mills Avenue, Orlando, Florida 32803

I understand and agree that I am financially responsible for appropriate fees associated with my request in accordance with Florida Administrative Code, Rule 64B-10.003 which states that "(1) Any person licensed pursuant to Chapter 458, Florida Statutes, required to release copies of patient medical records may condition such release upon payment by the requesting party of the reasonable costs of reproducing the records. (2) Reasonable costs of reproducing copies of written or typed documents or reports shall not be more than the following: (a) For the first 25 pages, the cost shall be \$1.00 per page. (b) For each page in excess of 25 pages, the cost shall be 25 cents. (3) Reasonable costs of reproducing x-rays, and other special kinds of records shall be the actual costs. The phrase "actual costs" means the cost of the material and supplies used to duplicate the record, as well as the labor costs and overhead costs associated with such duplication."

The cost of postage related to mailing is a separate fee that may be charged and is unrelated to the costs of reproduction.

Signature of Patient : _____ Print Name: _____

Signed by Personal Representative/Guardian (if applicable): _____ Print Name: _____

Description of personal representative/guardian authority to act on behalf of the patient: _____

Witness Signature: _____ Print Name: _____ Date Signed: ____ day of _____, 20____

I Acknowledge Receiving a Copy of This Authorization: _____ (Patient or Personal Representative/Guardian)

For Internal Purposes Only

Completed by: _____ Date completed: _____ Fax Pick-up Mailed Other: _____