

CFPG Patient Authorization For Use & Disclosure of Protected Health Information

Please Print

Patient Information

Patient Name: _____ Birth Date: _____ Social: _____

Authorization

By signing this authorization, I authorize *Central Florida Pulmonary Group, P.A.* to **obtain/release** certain protected health information (PHI) about me from or to:

(Name and address of entity being asked to release or to obtain information from)

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
- 10916 Dylan Loren Circle, Orlando, Florida 32825
- 610 Jasmine Road, Altamonte Springs, Florida 32701

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 _____

My complete medical record Other _____

I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on _____ (date supplied by patient); (3) under the following condition(s): _____

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.

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: _____ Date: _____

Signed by Personal Representative/Guardian: _____ Print Name: _____ Date: _____

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

Witness Signature: _____ Print Name: _____ Date: _____

For Internal Purposes Only

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