Indian River Internal Medicine, LLC

E. Luis Prieto, MD

Authorization for Use or Disclosure of Medical Records/PHI

Patient Name:_____ Date of Birth: _____

Social Security Number: _____

I authorize my physician and/or administrative and clinical staff of _____ to disclose the following protected heath information to:

Name of Person or Facility _____

Address _____

Information to be disclosed: (x)

( ) All records ( ) History & Physical ( ) Progress Notes
( ) Lab Reports ( ) Radiology Reports ( ) Operative Reports
( ) HIV **(MUST BE MAILED ONLY)**
( ) Psychiatric Evaluation **(MUST BE MAILED ONLY)**
( ) Other _____

Please exclude the following specific information:

_____

_____

This authorization covers care provided from _____ to _____.

Purpose of disclosure:

( ) Medical ( ) Employer ( ) Insurance ( ) Attorney ( ) At request of individual
( ) Other_____

Check One
( ) Release this information one time only.
( ) This release is good from the date signed until _____, at which time authorization to use or disclose this protected health information expires (No longer than 180 days)
( ) This release expires 180 days from today

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Contact at 7935 Bay Street, Suite 3, Sebastian, FL 32958. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Personal Representative Relationship

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