

# Surgical Group of Gainesville

Authorization for Release of Protected Health Information (PHI)

Section A: This section must be completed for all Authorizations					
<b>Patient Name:</b>		<b>Birth Date:</b>		<b>Social Security No. (optional):</b>	
<b>Provider's Name:</b>		<b>Recipient's Name:</b>			
<b>Provider's Address:</b>		<b>Address 1:</b>			
		<b>Address 2:</b>			
		<b>City:</b> Gainesville		<b>State:</b> FL	<b>Zip:</b> 32605
This authorization will expire on the following: (Fill in the Date or the Event but not both.)					
<b>Date:</b>			<b>Event:</b>		
<b>Purpose of disclosure:</b>					
<b>Description of information to be used or disclosed</b>					
Is this request for psychotherapy notes? <input type="checkbox"/> Yes, then this is the only item you may request on this authorization. You must submit another authorization for other items below. <input type="checkbox"/> No, then you may check as many items below as you need.					
<b>Description:</b>	<b>Date(s):</b>	<b>Description:</b>	<b>Date(s):</b>	<b>Description:</b>	<b>Date(s):</b>
<input type="checkbox"/> All PHI in medical record <input type="checkbox"/> Admission form <input type="checkbox"/> Dictation reports <input type="checkbox"/> Physician orders <input type="checkbox"/> Intake/outtake <input type="checkbox"/> Clinical Test <input type="checkbox"/> Medication Sheets		<input type="checkbox"/> Operative Information <input type="checkbox"/> Cath lab <input type="checkbox"/> Special test/therapy <input type="checkbox"/> Rhythm Strips <input type="checkbox"/> Nursing Information <input type="checkbox"/> Transfer forms <input type="checkbox"/> ER Information		<input type="checkbox"/> Labor/delivery sum. <input type="checkbox"/> OB nursing assess <input type="checkbox"/> Postpartum flow sheet <input type="checkbox"/> Itemized bill: <input type="checkbox"/> UB-92: <input type="checkbox"/> Other: <input type="checkbox"/> Other:	
I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial)					
I understand that: <ol style="list-style-type: none"> <li>1. I may refuse to sign this authorization and that it is strictly voluntary.</li> <li>2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.</li> <li>3. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.</li> <li>4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be redisclosed.</li> <li>5. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.</li> <li>6. I get a copy of this form after I sign it.</li> </ol>					
<b>Section B: Is the request of PHI for the purpose of marketing?</b>					
If yes, the health plan or health care provider must complete Section B, otherwise skip to Section C.					
Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, describe:					
<b>Section C: Signatures</b>					
I have read the above and authorize the disclosure of the protected health information as stated.					
<b>Signature of Patient/Patient's Representative:</b>				<b>Date:</b>	
<b>Print Name of Patient's Representative:</b>				<b>Relationship to Patient:</b>	