AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

Date of Birth:

NAME OF PATIENT		SS#	

TO: (Name, Address, Phone of **Recipient** of Records)						
Name				Phone		
Address						
City/State Zip	City		State		Zip	

Recipient FAX:

RECORDS FROM (Who is **Releasing** the Records):						
Name	Pinellas Medical Associates			Phone	727-528-6100	
Address	5880 49th St N Suite 104			Fax 727-528-7895		
City/State Zip	City	Saint Petersburg	State	FL	Zip	33709

For the Following Purposes:

☐	Continued Medical Care	☐	Personal Information	☐	Legal Follow-up
☐	Disability Insurance	☐	Other:		

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information And/or Medical Records, If Such Information And/or Records Exist:

☐	Please send the entire Medical Record (all information) to the above named recipient.				
☐	Office Notes and Reports	☐	Most recent one year history	☐	Most recent three-year history
☐	Rx History	☐	Transcribed hospital reports	☐	Laboratory reports
☐	Billing Statements	☐	Diagnostic Reports	☐	Diagnostic Films
☐	Others Listed Here:				

The Following Items Must Be Initialed to NOT be included in the use and/or disclosure:

_____ HIV/AIDS relate information and/or records HBV, TB or Other Communicable Diseases
_____ Mental Health Information and/or Records
_____ Domestic Violence
_____ Genetic Testing Information and/or records
_____ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:
_____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.
I, further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.
Finally, I understand that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date): _____.

Print Patient's Name: _____ Date: _____

Signature of Patient or Patient's Legal Representative: _____

Print Name of Legal Representative (if applicable): _____

Relationship to patient: _____

**** Medical Record Company will communicate via email. Please supply email address:**