Tampa Family Health Centers
P.O. Box 82969, Tampa, Florida 33612
(813) 866-0930 Fax: (813) 866-0929

Authorization for Disclosure of Health Information

Patient Name: _____

SSN: _____ Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:
   Name: _____
   Phone: _____ Fax: _____
   Address: _____
   City: _____ State: _____ Zip: _____
3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate)
   ❑ Complete Health Records ❑ Physical Exam ❑ Immunization Records
   ❑ Lab Results / X-Ray Reports ❑ Consultation Reports
   ❑ Other (please specify): _____
4. I understand that the information in my health record may include information relating to sexually transmitted disease, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
5. **This information may be disclosed to and used by the following individual or organization:**
   Name: _____
   Phone: _____ Fax: _____
   Address: _____
   City: _____ State: _____ Zip: _____
   For the purpose of: _____
6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the management of this facility. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization *will not expire*.
7. If I fail to specify an expiration date, event, or condition, this authorization *will not expire*. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the infomation may not be protected by federal rules. If I have questions regarding the disclosure of my health information, I can contact this facility's management.

_____ _____
Signature of Patient or Legal Representative Signature of Witness

_____ _____
Date Date