

Tampa Obstetrics, P.A.
Medical Records Department
505 Oakfield Drive, Brandon, FL 33511
(813) 654-2273 TEL / (813) 654-1384 FAX

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Please read both sides of this form carefully. The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), which became effective April 14, 2003, requires that all of the following elements must be completed for an authorization to be valid.

Patient Name _____
Street Address _____
City, State, and Zip Code _____
Phone Number _____
Date of Birth _____
Medical Record Number _____

I hereby authorize that the protected health information regarding the above-named person be forwarded:

From: Person/Organization _____
Address _____
City _____ State _____ Zip _____

To: Person/Organization _____
(Recipient) Address _____
City _____ State _____ Zip _____

Purpose or Need for Information:

Disclosure will include (check all that apply):

_____ Face Sheet	_____ History & Physical	_____ Laboratory Report
_____ Operative Report	_____ Discharge Summary	_____ Progress/Physician Notes
_____ X-ray/Radiology Report	_____ Pathology Report	_____ Emergency Report
_____ Nurses Notes	_____ EKG/EMG/EEG Report	_____ Consultation Report
_____ Other: _____		

Records for the period (dates) from _____ to _____

(Continued on reverse.)

I understand that I must check one or more of the following types of health information that I do not want released to the above-named Recipient. I understand that if I do not check any of the following three items, the health information released to the named Recipient may include any of the following:

_____ Diagnosis, evaluation, and/or treatment for alcohol and/or drug abuse

_____ Records of HTLV-III or HIV testing (AIDS test) result, diagnosis, and/or treatment

_____ Psychiatric, psychological records or evaluation and/or treatment for mental, physical, and/or emotional illness including narrative summary, tests, social work assessment, medication, psychiatric examination, progress notes, consultations, treatment plans, and/or evaluation

I also understand that this Authorization is subject to revocation/withdrawal by me at any time in writing to the medical record contact person at this site of care except to the extent the action has already been taken to release this information. This Authorization shall remain valid unless revoked but **will expire in one year after signing**. I have a right to inspect a copy of the health information to be released, and if I do not sign this Authorization, the organization named above will not release my health information. The above named person/organization will not refuse to treat me based on whether I agree to allow my health information to be used and disclosed to others.

Signature of Patient

Date

Signature of Parent/Legal Guardian/Personal Representative

Relationship to Patient

Witness

Re-disclosure: Notice is hereby given to the patient or legal representative signing this Authorization that Tampa Obstetrics, P.A. cannot guarantee that the Recipient receiving the requested health information will not re-disclose any or all of it to others. Notice is hereby given to the Recipient that law prohibits the re-disclosure of any health information regarding drug and/or alcohol abuse, HIV, and mental health treatment.

Please tell us why you are requesting your health information by checking one of the following:

_____ I am remaining a Tampa Obstetrics patient, but also seeking care from an outside physician.

_____ I am leaving Tampa Obstetrics because:

_____ I am moving out of Tampa Obstetrics' service area.

_____ I have a new insurance plan (please supply name _____).

_____ I was dissatisfied with some aspect of Tampa Obstetrics.

_____ Other: _____