RIVERS FAMILY MEDICINE P.A.

1503 Buenos Aires Blvd, Bldg 110, The Villages, FL 32159
Phone: 352-205-4302 Fax: 352-430-0468

Patient Name: LAST FIRST MI _____ Date of Birth _____ Social Security Number

I hereby authorize Rivers Family Medicine P.A. to OBTAIN my medical records from:

Name:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

INFORMATION TO BE DISCLOSED: ( ) Complete chart, ( ) Records from ___/___/___ to ___/___/___ ,
( ) Other - please specify:_____

PURPOSE OF DISCLOSURE: ( ) Continuing Care, ( ) Payment of Claim, ( ) School, ( ) Legal,
( ) For Personal Use, ( ) Other - please specify:_____

I specifically authorize the release of information relating to: (for consent initial by each option)
_____ Substance abuse (including alcohol/drug use)
_____ Behavioral Health
_____ HIV related information (AIDS related testing)
_____Communicable diseases

ACKOWLEDGEMENT OF UNDERSTANDING:

- I understand the expiration date of this authorization is one year.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal privacy regulations.
by the recipient and no longer protected by Federal privacy regulations.
- I understand by authorizing this use or disclosure of information, there will be no conditions placed on my health care or payment for my health care.
- I understand I have a right to receive a copy of this form after I have signed it.
- I understand that in compliance with Florida Law, I may be required to pay a fee for retrieval and photocopying of records and/or supervising inspection of medical records.

_____ _____ _____
Signature of patient, parent of minor, or personal representative Relationship Date

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION