

EDWARD H. FARRIOR, M.D., F.A.C.S.
AUTHORIZATION FOR USE OF PROTECTED HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____ Medical Record #: _____

1. I authorize _____ to disclose my health information specific to the following date or time period: _____
2. Individual or entity authorized to receive my health information: _____

3. Purpose for which disclosure is to be made: _____
4. Information to be disclosed:

<input type="checkbox"/> Practitioner Summary	<input type="checkbox"/> Emergency Room Report	<input type="checkbox"/> X-ray Records
<input type="checkbox"/> History & Physical Exam	<input type="checkbox"/> Laboratory Report	<input type="checkbox"/> Consultation
<input type="checkbox"/> Office Chart Notes	<input type="checkbox"/> Radiology Report	<input type="checkbox"/> Rx
<input type="checkbox"/> All Medical Records	<input type="checkbox"/> Medical Clearance Report	

I understand that this will include health information relating to (check if applicable):
 HIV (Human Immunodeficiency Virus) infection Mental Health
 Treatment for alcohol and/or drug abuse Genetic Testing

5. Referring physicians will receive information on care provided following your visits or any other physician you designate. Designated Physician: _____
6. Our current policy is to call your home for appointment reminders and for follow up medical care. If you do not want us to call your home, please provide us with an alternate plan to contact you. Alternate plan: _____
7. I understand that if the person(s) or entity that receives the information is not a healthcare provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and is no longer protected by those regulations. Therefore, I release Edward H. Fariior, M., D., F.A.C.S., its employees, and my physician(s) from all liability arising from this disclosure of my health information.
8. I understand that I may inspect or request copies of any information disclosed by this authorization. It is my understanding that this authorization will expire in 90 days from the date signed below. I understand that I may revoke this authorization by notifying, in writing, the Medical Records Department, knowing that previously disclosed information would not be subject to my revocation request.
9. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment or my eligibility for benefits.

Signature: Patient or Legal Representative Date Signature of Witness Date

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I certify that I have received a copy of Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of this facility's health care operations. The Notice of Privacy Practices also describes my rights and the facility's duties with respect to my protected health information. The Notice of Privacy Practices is posted in the office of Edward H. Fariior, M.D., F.A.C.S., located at 2908 W. Azeele St., Tampa, Florida, 33609-3110.

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority