Magnolia Medical Clinic, P.A.
131 Magnolia Avenue SE
Fort Walton Beach, FL 32548

Authorization for Disclosure of Health Information

Patient's Name: _____

Date of Birth: _____ Phone: (_____) _____

Address: _____

City: _____ State: _____ Zip: _____

1. I authorize the use of disclosure of the above named individual's health information as described below.
2. The following organization is authorized to make the disclosure:

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3. The type and amount of information to be used or disclosed is as follows: (include dates when appropriate)

_____ Complete health records
_____ Physical Exam
_____ Immunization Record
_____ Lab results/X-ray reports
_____ Consultation reports
_____ Other (please specify): _____

_____

4. I understand that the above 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: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

Name: _____ DOB: _____ Name: _____ DOB: _____

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 health information management department. 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 expire on the following date, event, or condition:

_____

7. If I fail to specify an expiration date, event or condition, this authorization will expire one year from the signature date unless renewed. 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 unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact:
Sandy Johnson, Privacy Officer for Magnolia Medical Clinic, P.A.

_____ _____
Signature of patient or legal representative Signature of witness

Date: _____ Date: _____

RENEWAL INFORMATION

Date	Signature	Witness	Date