West Coast Family Practice
For your Health
www.wctampa.com

Gail Sadler, APRN-BC Theata J. Merritt, APRN-BC

11018 N. Dale Mabry Hwy, Ste. 401, Tampa, FL 33618 PH: 813-961-9393 FX: 813-960-9020

AUTHORIZATION TO USE OR DISCLOSE MEDICAL RECORDS

I give authorization to the provider listed below to disclose a copy of the specific health/medical information identified below:

NAME OF PATIENT		DOB	/ /	SS# last four:

TO: (Name, Address, Phone of **Recipient** of Records) (or as checked office location above)						
Name	**WEST COAST FAMILY PRACTICE**			Phone	**813-961-9393**	
Address	**11018 N. DALE MABRY HWY, SUITE 401**					
City/State Zip	City	**TAMPA**	State	**FLORIDA**	Zip	**33618**

RECORDS FROM (Who is **Releasing** the Records):						
Name				Phone		
Address						
City/State Zip	City		State		Zip	

By Checking the Boxes Below, I Specifically Authorize the Use and/or Disclosure of the Following Health Information and/or Medical Records, If Such Information and/or Records Exist:

	Please send the entire Medical Record (all information) to the above named recipient.				
	Office Notes and Reports		Most recent one year history		Most recent three-year history
	Rx History		Transcribed hospital reports		Laboratory reports
	Billing Statements		Diagnostic Reports		Diagnostic Films
	Others Listed Here:				
For dates: From:			To:		

The Following Items Must Be Initialed to Be Included in the Use And/or Disclosure:

_____ I understand that a complete copy of my medical records may include confidential information such as mental health, alcohol and/or drug abuse, HIV and other STD results. I also understand that if I want this information excluded from the copies, I must indicate this in writing.

_____ Drug/Alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.) Describe:

_____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by HIPAA and other federal and state regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand that the person I am authorizing to use and/or disclose the information may not receive compensation for doing so.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment of my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that **I may revoke this authorization**, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless Revoked Earlier, this Authorization Will Expire in Six (6) Months from the Date of Signing or until (Insert Date)_____.

Patient Name (Print):	
Patient Signature:	Date:
Legal Guardian Name:	Legal Rep. Signature:

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STANDING AUTHORIZATION FOR DISCLOSURE OF INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the use or disclosure of protected health information (PHI) other than treatment, payment or healthcare operations (TPO). Others that are permitted to receive disclosure of information by law include: Judicial proceedings, coroners, medical examiners, research purposes, law enforcement, worker's compensation and other areas so designated by law.

Release or disclosure of information to family members, friends, clergy or others involved in a patient's care is NOT included in the General Rule and require specific authorization for disclosure of information.

If you would like us to share your PHI with family members or others, please fill in the information below for each individual, designate if unrestricted or limited release of information and date and initial each authorization. Please note that ABSOLUTELY NO INFORMATION WILL BE DISCLOSED to spouses, children, other family members, care givers or friends if not authorized below. You may rescind or change any authorization by a written request at any time.

1. Please list the family members or other person(s), if any, whom we may inform about your general medical condition and your diagnosis, records, reports (including treatment, payment and health care operations):

Name:	Relation:	Phone;	☐ All Access ☐Appointments ☐Lab results
Name:	Relation:	Phone:	☐ All Access ☐Appointments ☐Lab results
Name:	Relation:	Phone:	☐ All Access ☐Appointments ☐Lab results
Name:	Relation:	Phone:	☐ All Access ☐Appointments ☐Lab results

2. Please list the family members or others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**.

Name:	Relation:	Phone:
Name:	Relation:	Phone:

3. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent ***if other than your home***. **(Confidential Communications):**

4. Print the telephone number or email address where you want to receive calls about your appointments, lab and x-ray results or other health care information ***if other than your home.***

Phone: _____ ***Email:*** _____

5. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or Voice Mail?
☐ YES ☐ NO

I understand the Privacy Protection Act and have been offered a copy of the Notice of Privacy Policies and do hereby authorize to disclose as I have identified above.

Patient Name:	**Date:**
Patient Signature:	
Legal Guardian/Representative Name:	**Legal Rep Signature:**