Tallahassee Primary Care Associates
Our primary care is you.

Patient Authorization for Release of Protected Health Information and Medical Records

Patient's Name ____ Date of Birth ______________
(Last, First, Middle/Maiden)

Patient's Address:______________________ City:__________________ State:_______ Zip:________

Phone Numbers:______________________

I authorize my physician and/or administrative and clinical staff at Tallahassee Primary Care Associates or other healthcare provider as indicated below to release the medical information specified below to the following person or entity:

Person or Entity to Receive Information:	**Person or Entity to Disclose Information:**
Name/Organization:______________________	Name/Organization: ______________________
Address: ______________________	Address: ______________________
City, State, Zip: ______________________	City, State, Zip: ______________________
Phone: __________ Fax: __________	Phone: __________ Fax: __________

SPECIFIC INFORMATION TO BE DISCLOSED (check all that apply):

__ Complete Medical Record
__ Billing Records
__ Office Notes
__ Ultrasound Reports
__ Lab Reports
__ Surgery Records
__Mammogram Reports
__ Obstetrical (OB) Records
__ Pap Smear / Biopsy Reports
__Other (specify): ______________

DATES OF SERVICE: ______________________________

PURPOSE:___ Changing Physicians ___ Personal Copy to Patient ___ Attorney ___ Insurance___ Workers' Compensation

Other ____

This authorization will expire on: ____________(If no date is specified, it will expire 60 days after date signed).

CHECK AND INITIAL BELOW:

___ I DO___ I DO NOT authorize the release of information pertaining to specific laboratory tests of **HIV** infection (Human Immunodeficiency Virus, the causative agent of AIDS), the results of such tests, the diagnosis of **Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions**, and all medical records and clinical information relating thereto.
Initials of individual giving authorization: _______

___ I DO___ I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information pertaining to any evaluation, treatment and/or hospitalization for **mental health or psychiatric conditions**.
Initials of individual giving authorization: _______

___ I DO___ I DO NOT authorize the release of all information, including but not limited to the medical/clinical record and other information relating to any evaluation, treatment and/or hospitalization for **drug or alcohol abuse, drug-related** and/or **alcohol-related** treatment.
Initials of individual giving authorization. _______

I have read and understand the nature of this authorization and I have been provided a copy of TPCA's Notice of Privacy Policy and the opportunity to review the same. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's Privacy Officer at ***Tallahassee Primary Care Associates, P.A., Administrative Offices 1803 Miccosukee Commons Drive, Tallahassee, Florida 32308, Attn: Compliance Officer or email Compliance@TallahasseePrimaryCare.com.*** I understand that a revocation is not effective to the extent that my physician or Tallahassee Primary Care Associates has taken action in reliance upon this authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I also understand that such revocation does not affect TPCA's right to use or disclose any information as otherwise provided for in the Notice of Privacy Policy. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party. When my health information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule and/or other applicable federal and state laws. Releaser and its agents and employees are hereby authorized to obtain, inspect and reproduce such records and/or information and are hereby relieved of any responsibility of liability that may arise from the release or reproduction of such records and or information.

______________________________ ______________________________
Signature of Patient or Patient's Representative Witness

______________________________ ______________________________
Relationship to Patient Date

(If applicable, attach document of guardianship or Power of Attorney)

FEE FOR COPIES **Tallahassee Primary Care Associates follows applicable Federal Law for copying charges as outlined in the Code of Federal Regulations Section 164.524.**