FLORIDA PHYSICIANS
MEDICAL GROUP

FPMG 25.3
Exhibit A

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (MEDICAL RECORD)

SECTION A: Must be completed for ALL Authorizations

By signing this Authorization, I hereby authorize and permit the use and/or disclosure of my protected health information (medical record) for the limited purpose(s), and in the limited manner, described in this form. In addition, I understand that this Authorization is completely voluntary and I am signing it under my own free will.

Patient Name: ______________________ Patient # ______________________

Home Address: ______________________ Date of Birth: ______________________

Persons/organizations providing the information: (Complete w/Address)

Persons/organizations receiving this information: (Complete w/Address)

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Specific description of information (including date(s)) to be used and/or disclosed about me:

*** The following items must be initialed to be included in the use or disclosure of other health information:**

- ☐ * HIV / AIDS related health information and/or records.
- ☐ * Mental health information and/or records.
- ☐ * Genetic testing information and/or records.
- ☐ * Drug/alcohol diagnosis, treatment and/or referral information (Federal regulations require a description of how mucha nd what kind of information is to be disclosed. Federal law prohibits the disclosure of such information.)

SECTION B: Must be completed only if FPMG has requested the Authorization

1. FPMG must complete the following:

   a. What is the purpose of the use or disclosure? (Check one.)

   - ☐ At the patient's (or the patient's representative's) request or direction.
   - ☐ For marketing.
   - ☐ For fundraising.
   - ☐ Other (describe):

   b. Will the FPMG practice requesting the Authorization, receive financial or in-kind compensation, directly or indirectly, in exchange for using or disclosing the health information described above?

   ☐ Yes ☐ No

2. The patient or the patient's representative **must read and initial** the following statements:

   a. I understand that my health care and the payment for my health care will NOT be affected if I DO NOT sign this form. **Initial:** _______

   b. I understand that I may see and copy the information described on this form if I ask for it, and that I get a copy of this form after I sign it. **Initial:** _______

SECTION C: Must be completed for ALL Authorizations

The patient or the patient's representative must read and initial the following statements:

1. I understand that this Authorization will expire. (Please choose one.)

   No expiration (permitted only for Authorizations used to create or maintain research databases or repositories). **Initial:** _______

   On ________________ (DD/MM/YYYY) **Initial:** _______
   Date

   When the following event occurs [ ] **Initial:** _______

____ _______________

Signature of Patient or Patient's Representative **Date**
(Form MUST be completed before signing)

Print Name of Patient's Representative: ____

Relationship to the Patient: ____

Reason Authorization is signed by the Patient's Representative: (Check one.)

☐ Minor
☐ Incompetent
☐ Other (Explain)____

*** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**

**If this Authorization form authorizes use and/or disclosure of psychotherapy notes, it may not be used to authorize the use and/or disclosure of any other protected health information. A separate Authorization form is needed for any other use and/or disclosure.*