

**SOUTHERN MEDICAL GROUP, P.A.**

1300 Medical Drive

Tallahassee, FL 32308

(850) 216-0100

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_

**Information To Be Released – Covering the Periods of Health Care**

From (date) \_\_\_\_\_ to (date) \_\_\_\_\_

**Please check type of information to be released:**

- |                                    |  |
|------------------------------------|--|
| _____ Complete health record       | _____ History and physical examination |
| _____ Complete billing record      | _____ Laboratory results               |
| _____ Consultation reports         | _____ X-ray reports                    |
| _____ Discharge summary            | _____ Pathology reports                |
| _____ Other (please specify) _____ |  |

**Purpose of Request**

- \_\_\_\_\_ Treatment or Consultation  
 \_\_\_\_\_ At the request of the patient  
 \_\_\_\_\_ Billing or claims payment  
 \_\_\_\_\_ Other (specify) \_\_\_\_\_

**Request Copies of My Records From:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

**Send Copies of My Records To:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_

**Drug, Alcohol Abuse, Psychiatric, and/or HIV/AIDS Records Release**

I understand if my medical or billing records or psychotherapy notes contain information in reference to drug and/or alcohol abuse, psychiatric care, sexually transmitted disease, Hepatitis B or C testing, and/or other sensitive information, I agree to its release. (Circle One)

<b>Drug/Alcohol Abuse</b>	Yes	No	<b>Psychiatric</b>	Yes	No	<b>HIV/AIDS</b>	Yes	No
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**I understand that:**

- I may revoke this authorization in writing 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 (Medical Records) Department. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will expire on \_\_\_\_\_. If no date is specified, this authorization will expire six months after the date it is signed by the Patient or the Patient's Legal Representative.
- I understand that once the above information is disclosed, it may be re-disclosed by the recipient and the information may or may not be protected by federal privacy laws or regulations.
- I understand authorizing the use or disclosure of the information identified above is voluntary. I do not need to sign this form to ensure healthcare treatment.
- I have the right to receive a copy of this authorization.

I have fully read and understand the nature of this Authorization and accept it's terms. I authorize Southern Medical Group, P.A. to disclose and release the specific PHI, as indicated, for the specific use(s) and purpose(s) listed.

Signature of Patient or Legal Representative\* \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
\*State relationship to patient and attach applicable documents for guardianship and/or Power of Attorney.

Witness \_\_\_\_\_ Date \_\_\_\_\_