I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

I authorize South Florida Internal Medicine & Primary Care to request or disclose (release) the following information from medical records of:

PATIENT NAME:
DATE OF BIRTH:
ADDRESS:
CITY:
STATE:
ZIP CODE:
TELEPHONE:
MEDICAL RECORD NO:

South Florida Internal Medicine & Primary Care

680 Second Avenue North, Suite 203 Naples FL 34102
(239) 330-1382   305-570-4385 fax

Covering the period(s) of health care (select only one):

[ ] All past and future dates
[ ] All past dates   [ ] All future dates
[ ] From _________________ to __________________

Information to be disclosed:

[ ] Complete health record(s), including all images (x-rays, photographs, etc.)
[ ] Complete health record(s), excluding all images
[ ] Other ____

OR

Select from the following (check as many as apply):
[ ] Discharge Summary
[ ] Progress Notes
[ ] History and Physical Examination
[ ] Laboratory Tests
[ ] Consultation Reports
[ ] X-ray reports
[ ] AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus)
[ ] Mental health care or services
[ ] Psychotherapy Notes
[ ] Treatment for alcohol and/or drug abuse
[ ] Photographs, videotapes, digital or other images

This information is to be disclosed to the following individual or entity:

NAME:
ADDRESS:
CITY:
STATE:
ZIP CODE:

Signature: Date:

Name: