ALL AMERICAN FAMILY & GERIATRIC CARE, PLLC

PATIENT AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize All American Family and Geriatric Care to use or disclose my individually identifiable health information as described below. I understand that the information I authorize another person or entity to receive may be re-disclosed by them, and may no longer be protected by federal privacy regulations. This authorization is for the Practice to:

RELEASE TO / OBTAIN FROM
(Circle one)

_____

_____

_____
City State Zip

_____
Phone Fax

Note: HIPAA allows a maximum of 30 days to prepare copies of your records. You may be charged a fee for duplication of records which will be clarified with you prior to preparing the copies.

Please mail all records to:
9677 Seminole Blvd.
Seminole, FL 33772
Attn: Medical Records
TEL: 727-490-9096 FAX: 727-490-9299

The information to be used/disclosed is specifically described below:

_____ Office Notes _____ Entire Record _____ Diagnostics/Labwork _____ Other

Purpose of Disclosure:

_____ Attorney/Legal _____ Insurance/Reimbursement _____ Personal Use _____ Continued Medical Care

_____ Other_____

I understand that this authorization is voluntary and that I may refuse to sign it. I understand that, if I refuse to sign this authorization, my refusal will not affect my ability to obtain treatment. I understand that I may revoke this authorization at any time by notifying in writing the Privacy Officer @ All American Family and Geriatric Care 9677 Seminole Blvd., Seminole, FL 33772. However, the revocation will not be valid to the extent that the Practice has taken action in reliance on this authorization or to the extent this authorization is executed as a condition for obtaining insurance coverage. My Physician will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

This authorization expires on/upon: _____
(Insert Applicable Date or Event)

Patient Name: _____

_____
Signature of patient/representative Date

Date of Birth: _____ Phone:_____

_____
Print Name Relationship to Patient

Address: _____

City, State, Zip: _____

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FOR MEDICAL RECORD USE ONLY:

Request completed: _____ by:_____ Mail/Fax/Pick-up:_____
Date Initials (circle one)