This box is ONLY to be used by FHC Offices
☐ Copies given to Patient
Date: __________
By: ______________

Family Health Centers
OF SOUTHWEST FLORIDA, INC.

Authorization for Release of Protected Health Information as Required by the Health Insurance Portability and Accountability Act of 1996

(To be completed by the patient or the patient's authorized representative:)

____
Patient's Name *DOB* *Chart#*

____
Street Address *City* *State* *Zip Code*

____________________ ____________________
Telephone *Fax no.*

I hereby authorize:

☐ Family Health Centers of Southwest Florida, Inc., **or**

☐ ____
Name of Physician or Provider

____
Street Address *City* *State* *Zip Code*

____________________ ____________________
Telephone *Fax no.*

To release my confidential health information, as described below, to:

☐ Me ☐ The staff at Family Health Centers of Southwest Florida, Inc., **or**

☐ ____
Name/Organization Name

____
Street Address *City* *State* *Zip Code*

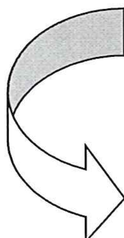
____________________ ____________________
Telephone *Fax no.*

In the following manner:

☐ Mail ☐ Fax ☐ To be picked-up ☐ Facility: ____________________

My authorization is for the use and disclosure of the following records:

You must INITIAL next to each record requested: (If applicable)



_____ Statements of charges and payments
_____ Records of Family Health Centers of Southwest Florida, Inc. visits
_____ Mental health records
_____ Dental records
_____ X-rays and other images
_____ AIDS or HIV information STD/Communicable Diseases
_____ Drug and / or Alcohol
_____ Other: ______________________________
_____ All of the above

For information generated on the following date: __________________

My authorization is given freely with the understanding that:

- I may refuse to sign this authorization.
- I may revoke this authorization at any time, except where information has already been released in reliance on my authorization, provided that my revocation is in writing.
- Family Health Centers of Southwest Florida, Inc. may not condition my treatment, payment, and enrollment in a health plan, or eligibility for benefits on my provision of this authorization.
- This authorization is valid for a _____ day period from the date it is signed or sooner if so specified by me, as indicated below.
- A photocopy or fax of this authorization is as valid as the original.
- Family Health Centers of Southwest Florida, Inc., its directors, officers, employees, agents and volunteers are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
- I will be given a copy of this signed authorization if the authorization is at the request of Family Health Centers of Southwest Florida staff.

This authorization will expire on: ____________________________________

x ____________________________________ x ____________________
Patient's Signature *Date*

____________________________________ ____________________
Name of Parent or Personal Representative Signature (please print) *Date*

____
Description of Legal Authority to Act on Behalf of Patient

Patient's Acknowledgement of Receipt

To be completed by the patient, the patient's personal representative or other person designated in the authorization to receive the requested protected health information when the patient, representative or other person appears at Family Health Centers of Southwest Florida, Inc. in person to receive the information.

I hereby acknowledge that I have received the above requested health information:

Name (please print) ____________________________________

____________________________________ ____________________
Signature *Date*

This information is to be disclosed for the purpose of ______________________________

Are you leaving the practice _____***Yes No***______

Reason for transferring from Family Health Centers: ______________________________