Advanced Medical of Florida, LLC
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PATIENT RECORD AUTHORIZATION
To Permit Use and Disclosure of Patient Health Information

Name:_____ Date of Birth:_____

I am either the patient named above or the patient's legally authorized representative. By signing this form, I hereby authorize this facility to use or disclose to:

_____
Person to whom requested use or disclosure would be made

Myself _____ Mailing address: _____
_____
_____

The following protected health information is being requested (Ie, Records/Labs/Xray or ALL):
_____

Authorized information will be used and/or disclosed for the following purposes:
_____ At the request of the individual
_____ Other (please list each purpose)_____

If I revoke this authorization, I must do so in writing. I understand that I may refuse to sign this Authorization. I also understand that my treatment will not be conditioned on receiving my signature on this Authorization. I have been informed and understand that information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under federal medical privacy law.

_____ _____
Signature of Patient or Legal Representative Date

If Legal Representative, explain authority to act on behalf of the patient:
_____

If other than parent, please attach appropriate documentation if applicable.