AUTHORIZATION OF USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

Century Clinical Family Medicine LLC
1410 LPGA Blvd, Ste 140
Daytona Beach, FL 32117
Phone: (386)274-4750 Fax: (386)274-2499

This authorizes Century Clinical Family Medicine LLC as indicated below by checkmark , the release of medical data includes re-disclosure of medical information obtained from other providers in accordance with the patient's wishes to____________________________________at the following address:

_________________________________ ____ _________________________
Street City, State, Zip
Phone ( )_____________________ Fax( )_____________________

Patient Name: ____ DOB:_________
(Please Print)
Social Security #: ____

INFORMATION TO BE RELEASED

Dates of Service _____________________________ __ Consultation Report __ Operative Report
__ Face Sheet __Lab/Pathology Report __ X-ray Reports/Images
__ Immunizations **__ COMPLETE MEDICAL RECORDS** OTHER____________________

REASON FOR RELEASE OF RECORDS:

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected.

AUTHORIZATION FOR RELEASE OF SPECIFICALLY PROTECTED INFORMATION

I understand that the specified information to be released may include, but is not limited to: history, diagnosis, and/or treatment of tobacco, drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS). I request the release of the specific categories of information that I have INITIALED below:

____ _HIV TEST RESULTS: SPECIFY DATES:__________________________
_____ GENETIC TEST RESULTS (excludes therapeutic genetic test) TYPE OF TEST_______________
_____ ALCOHOL & DRUG ABUSE RECORDS
_____ RECORDS PERTAINING TO SEXUALLY TRANSMITTED DISEASES
_____ Confidential Details of Behavioral or Psychotherapy
_____ Confidential Details of Domestic Violence or Abuse
_____ Confidential Details of Sexual Assault & Counseling

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization. I understand I may be charged a retrieval/processing fee for copies of my medical records according to the Florida State Board of Medical Examiners. This authorization will expire One Hundred Eighty (180) days from the date of my signature unless I revoke the authorization prior to that time or unless otherwise specified by date, event, or condition as follows:

Date: ____________________________ Signature: ____________________________
Patient or Legally Authorized Representative

____
Printed Name