Patient Name___________________________________ **Date of Birth**:_______________

Address:____

Phone Number:__________________________

I authorize _______________________________ Phone #_________________ to share my health information with: *Associates of Internal Medicine, PA.*

Title: *Dr. Joanna Widdows, Donna Leonardo PA-C, Tyler Adams ARNP*

Address: 13660 Jog Road Suite B5, Delray Beach, FL. 33446 **Phone:** 561-498-7474 **Fax:** 561-819-6466

Purpose of disclosure: __Medical Care ___Legal ___Transferring to New Provider __other

Health information to be shared: ALL health records or date range ________/____________.

Or please pick what to share: Progress Notes, Labs, Diagnostic Testing.

Delivery Preference: ________ Pickup ________Mail _________ Fax

The following information will be released UNLESS you initial in the space provided:

___*Mental Health Records* ___ *Sexually Transmitted Disease* (STD) *records* __ *Genetic Testing*

___*Alcohol/drug abuse treatment* ___ *HIV/AIDS test results*

___ *Psychiatric Associates Addiction Treatment Program Records*

Duration and Revocation: *This authorization will remain in effect for one year from the date of the signature below, unless you specify a different date here:______ (date). You or your personal representative may revoke this authorization at an any time by providing written notice as specified in our Notice of Privacy Practices; however, your revocation will not apply to any previously release information.*

I understand that:

-A fee for the cost of processing this request may be charged.
-Once this information is shared with the recipient you specified above, how that recipient further discloses it may no longer be protected under federal and state privacy regulations.
-Associates of Internal Medicine may utilize a business associate or staff member to assist in fulfilling this request.
-Associates of Internal Medicine will not condition my ability to receive healthcare services on providing or refusing to provide authorization. The only circumstance where refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

Signature:

___________________________________ ________________________ __________________

Signature of Patient or Person Representative Print Name Date