EMERALD WATERS MEDICAL CLINIC

1005 College Blvd West, Suite B, Niceville, FL 32578-1060
Telephone: (850) 279-6815 /Fax: (850) 279-6817

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient's Printed Name: Last:___________________________________First:_____________________________MI:_____________

Date of Birth:_________________________ SSN:____________________________ Daytime phone#: ___________________________

I authorize **Emerald Waters Medical Clinic** to exchange protected health information only generated by this clinic as part of my care and treatment dating back to the last 6 months of care and starting from my last clinic visit, either from hard copy and/or by electronic means as following:

Printed Name/Agency:____

Address:(street)____(city)______________________________(state/zipcode)__________

Agency/Individual's Daytime Phone#:_________________________________ Fax #:____

Purpose of the request or disclosure: (Initial Selection)

________Continuity of Care _________Personal Use ________Other (specify)_______________________________________

Please initial by all Information to be Released/Disclosed:

______General Medical Record(s), including STD and TB ______Progress Notes ______History/Physical Results

______Immunizations ______Family Planning ______Prenatal Records ______Consultations _______PIP Notes/Records

______Diagnostic Test Reports (Specify type of test(s))____

I specifically authorize release of information relating to: (Initial Section)

______HIV test results for non-treatment purposes ______Substance Abuse Service Provider Records

______Psychiatric, Psychological or Psychotherapeutic Notes ______Other (as Specified)___________________________________

1. **Expiration Date:** This authorization will automatically expire one year from today's date unless otherwise specified.
2. **Redisclosure:** I understand that once the above information is disclosed/released, it may be redisclosed/re-released by the recipient and federal privacy laws or regulations may not protect the information. I also understand that prior and/or other medical provider's records requested by this clinic for the purpose to establish or update my care and treatment with Emerald Waters Medical Clinic will not be forwarded to a requesting medical provider office, clinic, or facility as part of requested records from Emerald Waters Medical Clinic.
3. **Conditioning:** I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse, sign this form.
4. **Revocation:** I understand that I have the right to revoke this authorization any time. If I revoke this authorization, I understand that I must do so in writing and that I must present my revocation. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare.

____ _________________________

Patient's Signature/Legal Guardian/Auth Representative **Date**

____ _________________________

Witness' Signature If Required **Date**