



April R. Smith-Gonzalez, DO MPH
Board Certified in Family Medicine and Osteopathic Manipulative Treatment

Authorization and/or Disclosure of Protected Health Information

Patient Name: _____ Today's Date: ____/____/____

Date of Birth: ____/____/____ SSN: ____-____-____

Patient Address: _____

City: _____ State: _____ Zip: _____

Phone Number: ____-____-____

I hereby request:

____ Release of my records by individual(s) specified below to 'OSTEOPATHIC Family Wellness Center.'

The Purpose of this request:

____ At my request

____ Other: _____

The description of the specific protected health information to be accessed and/or disclosed:

My Medical Records for dates of service: ____/____/____ --- ____/____/____

Include the following: (please initial)

____ Radiology Report(s) ____ Consultation Pathology Report(s) ____ History & Physical Operative Report(s)

____ Laboratory Report(s) ____ HIV/AIDS ____ Mental Health

____ Other (specify) _____

I authorize:

Name of Dr. or Facility and Address: _____

Phone #: ____-____-____

FAX: ____-____-____

...to disclose the protected health information specified above to:

Osteopathic Family Wellness Center
Dr. April Smith-Gonzalez
5555 E. Michigan St. Suite 103
Orlando, FL. 32822
(407) 456-2977

FAX: 407-745-4688



I have read and understand the following statements: (please initial)

___ I understand that if I request a copy of the protected health information specified herein, 'OSTEOPATHIC Family Wellness Center' may impose a reasonable, cost-based fee for such access.

___ I understand that if I am denied access to all or a portion of my protected health information, the protected health information that I have been denied access to may not be disclosed as authorized in this Form.

___ I understand that the protected health information specified above may include mental health, substance abuse (e.g., drugs, alcohol) and/or HIV/AIDS status information and treatment records upon my request.

___ I understand this form is revocable, upon written notice to 'OSTEOPATHIC Family Wellness Center' it will not have any effect on any actions 'OSTEOPATHIC Family Wellness Center' took before it received the revocation. Unless otherwise revoked, this authorization will expire ninety (90) days from the date signed.

___ I understand that my authorized disclosure of protected health information to the individual specified above carries with it the potential for re-disclosure by such individual and may no longer be protected by the Federal privacy laws.

___ I understand that signing this form is completely voluntary and I am signing it under my own free will. I understand that 'OSTEOPATHIC Family Wellness Center' will not condition treatment, payment, enrollment in any health plans or my eligibility for benefits if I decide not to sign this Form.

___ By signing this Form, I hereby authorize and permit the use and/or disclosure of my protected health information for the limited purposes(s), and in the limited manner, described in the Form.

___ I understand I will receive a signed copy of this Form upon request.

___ If this form authorized the use and/or disclosure of psychotherapy notes, it may not be used to authorize the use and/or disclosure of any other protected health information.

Please read carefully before initialing:

___ I am the patient and I understand and agree to the provisions of this form/authorization.

___ I understand and agree to the provisions of this form **on behalf of the individual indicated below to be the patient**. I have signed my name individually and in my capacity as the **legal representative** of the patient and I have attached a copy of the **court order designating** me as the **guardian** of the patient, or documentation designating me as the **legal representative for the patient**.

Printed Name of Patient: _____ **Patient's Signature:** _____

Printed Name of Legal Representative _____ **Legal Representative's Signature** _____

Printed Name of Witness _____ **Witness' Signature:** _____