Florida Medical Clinic, P.A.

Authorization to Use/Disclose Protected Health Information

Patient Name:	DOB:
Account Number	SS#:

(Two Identifiers Required)

I authorize the use or disclosure of the above named individual's health information as described below.

The following individual or organization is authorized to make the disclosure (fill in the name of the entity releasing/providing the records):

Florida Medical Clinic, PA
Barkat U. Khan, M.D.
6719 Gall Blvd., Suite 207
Zephyrhills, FL 33542

The type and amount of information to be used or disclosed is as follows (include dates where appropriate):

Entire record	X-ray and imaging reports
Medication list	Consultation reports from (Insert doctor's name)
List of allergies	Problem list
Immunization record	Visits/encounters:
Most recent history and physical	Records from non-FMC providers
Laboratory results	Other (please specify):

I understand that the information in my health record may include information relating to sexually transmitted disease and other reportable diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include information about behavioral, psychiatric or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed to and used by the following individual or organization (fill in the name of the person or organization to whom we are giving the copied record to. Include phone and fax number):

Name/Dept.

Address/Telephone/Fax

For the purpose of:

Specify

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Florida Medical Clinic. I understand that this 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 when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition:

Specify

If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I **understand** that I may inspect or copy this information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Florida Medical Clinic's Privacy Officer at 352-567-0188.

Signature of Patient	Date:
Witness:	
If Signed by a Legal Representative, Relationship to the Patient	

it is expressly understood by me that the Provider is authorized to accept a copy or photocopy of this authorization with the same validity as though an original had been presented to the Provider.

Florida Medical Clinic, PA

Authorization to Share protected Health Information

Patient Name:	Second Form of Identification (SS#/DOB/Account #)

I authorize the physicians and staff of the following FMC department:

_____Psychiatry Staff Only_____

To share protected health information with the following persons:

_____ Relationship _____

_____ Relationship _____

_____ Relationship _____

This includes (please check all areas that apply):

Lab Results ☐	X-Ray Results ☐	Medication (Rx renewal and pick-up) ☐	Telephone Consults ☐	Hospital Information ☐
Insurance Information ☐	Dialysis Clinic Information ☐	Appointment Information ☐	All Medical Information ☐	Other (please specify): ☐

The authorization will be in effect until _____ (the expiration date). If no expiration date is identified, the authorization will be in effect until the patient revokes the authorization.

_____ _____

Patient's Signature Date